Completed Medication Administration Skill Competency Checklist

School Name: _____ School Year: _____

School Employee Name: _____ Job Title: _____

Date Competency Completed	Training RN, APRN, PA or MD Initials	Medication Administration Skill	Date Competency Completed	Training RN, APRN, PA or MD Initials	Medication Administration Skill
		Oral Medications			Intranasal Midazolam
		Liquid Medications			Narcan®
		Eye Drops/Ointment			Solu-Cortef® (Hydrocortisone Sodium Succinate)
		Ear Drops			Other:
		Topical Ointment/Cream			Other:
		Nasal Sprays			Other:
		Metered Dose Inhalers			
		Auvi-Q® (Epinephrine)			
		Adrenaclick® (Epinephrine)			
		EpiPen®			
		Neffy® (Epinephrine)			
		Baqsimi® (Glucagon)			
		Glucagon Injectable			
		Gvoke® (Glucagon)			
		Zegalogue® (Dasiglucagon)			
		Diastat®			
		Klonopin (Clonazepam) Buccal			
		Nayzilam® (Midazolam)			
		Voltoco® (Diazepam)			
		Vagal Nerve Stimulator (VNS)			

Upon the successful completion of all competency skills, both the trainer and trainee are required to sign the consent form below. This will finalize the training process and authorize the trainee to administer medications within the school setting.

Supervision of School Personnel Administering Medications

I have provided in-service training and have delegated to _____ to perform medication administration according to KRS 156.502, 702 KAR 1:160, KRS 158.838, and school district policies and procedures. This individual has demonstrated knowledge and understanding of the medication administration policies and procedures and has met the medication administration skill competency requirement as indicated in the above table.

_____ _____

Training RN, APRN, PA, or Physician Signature Date

I have been instructed in the school district's medication administration policies and procedures. I agree to administer medications in accordance with these policies and procedures, as trained and delegated to me under KRS 156.502, 702 KAR 1:160, and KRS 158.838. I understand that I must immediately report any new orders, changes in medication orders, changes in a student's health status, or medication errors to my supervising RN, APRN, PA, or Physician. Additionally, I acknowledge that I am not permitted to re-delegate this task to any other individual.

_____ _____

School Employee Date