COMPLETED MEDICATION ADMINISTRATION SKILL COMPETENCY CHECKLIST

School Name: ________________________________ School Year: ___________________

School Employee Name: ________________________ Position: _______________________

Date Competency Completed	Training RN, APRN or Physician Initials	Medication Administration Skill
		Oral medication
		Liquid medication
		Eye Drops or Ointment
		Ear Drops
		Topical Ointment or Creams
		Nasal Spray
		Metered Dose Inhaler (MDI)
		Glucagon Injectable
		EpiPen Injectable
		Diazepam (Diastat) Rectal Gel Suppository
		Clonazepam (Klonopin) Buccal Medication
		Narcan Nasal Spray

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. She/he 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 checkboxes.

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Training RN, ARNP or Physician Signature Date

I have been instructed in the school district's medication administration policies and procedures. I consent to perform medication administration according to these policies and procedures and as trained and delegated to me according to KRS 156.502, KRS 158.838 and 702 KAR 1:160. I understand that I am to immediately report to my supervising RN, ARNP or Physician, any new orders, change in medication orders, changes in student's health status, or discovery of a medication error and that I cannot re-delegate this task to any other person.

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School Employee Date

Adapted from: Maryland Department of Health & Mental Health (19). *Guidelines for in-servicing non-medical personnel on medication procedures*. Kentucky Department of Education, 2019.