**Medication Administration Delegation**

Employee \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Registered School Nurse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Review District medication delegation and administration policy and OSPI guidelines

[ ]  Review medication administration forms:

 Medication Authorization

 Medication Administration Record/Log

 Medication Error Report

 Receipt of Medication

 Field Trip Medication Administration Record/Log

[ ]  Review Medication Administration Procedure

Demonstrate medication administration (per procedure):

|  |  |  |
| --- | --- | --- |
| [ ]  Epinephrine auto injector [ ]  Inhaler[ ]  Nebulizer[ ]  Oral medication[ ]  Eye drops or ointment[ ]  Ear drops[ ]  Nasal spray[ ]  Topical ointment or cream[ ]  Transdermal patch[ ]  Gastrostomy tube medication[ ]  Review Confidentiality Statement (on reverse) | Other specific medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

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| --- | --- | --- | --- |
| **Initial Delegation Date:** | **Review date:** | **Review date:** | **Review date:** |
| *I hereby delegate the administration of the above medications at school during the \_\_\_\_\_\_\_\_\_school year to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*RN signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ***RN initials*** | ***RN initials*** | ***RN initials*** |
| *I accept the responsibility to give medications at school in conformity with the above directives. I accept the responsibility to safeguard health information confidentiality.*Employee signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ***Employee initials*** | ***Employee initials*** | ***Employee initials*** |

*Shared with permission from Royal School District*