**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):

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| --- | --- | --- |
| 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:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **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*