

ORIENTATION CHECKLIST FOR MEDICATION ADMINISTRATION

Person Trained: _____ **Title:** _____ **Initial date:** _____

Trainer: _____ **Title:** _____ **Initial date:** _____

Procedure: _____ **for** _____

Date /initial
Indicate N/A when non-applicable

	Demo	Return	Observed	Observed	Observed
States Name and Purpose of Routinely Given Medication					
Observes 5 Rights: Right Student, Medicine, Dose, Time, Route.					
Identifies hallmark signs of a medication reaction.					
Identifies Resources for gaining information.					
Secures medications upon completion.					
Accurately transcribes orders to medicine administration record.					
Interacts with students supportively					
Washes Hands					
Documents intake of medication, administration, and incidents.					

I (supervisor/trainer) trained the person designated as orientee in steps and skills listed above.

Signature/Title

Date

I (orientee) understand all steps and skills performed above and will consistently perform them properly as trained. I understand that I am to call an RN or the student's parent if I observe any problems or have any questions when I administer medication.

Signature/Title

Date

