

Massachusetts Department of Public Health

Administration of Prescription Medication

Test of Competency Checklist

To be completed at the time the Health Care Supervisor (other than a licensed medical professional) is assessed by the camp's Health Care Consultant for compliance with 105 CMR 430.160(I)(1).

Staff Information:

Health Care

Supervisor's Name: _____

Date of Assessment: _____

Medication Name(s): _____
 See attached list

Route: Oral Tablet Oral Liquid Drops: eye, ears, nose Topical

Checklist

Steps to Follow:	Check (✓)
Demonstrate safe handling and proper storage of medication.	
Demonstrate the ability to administer medication properly: <ul style="list-style-type: none">• accurately read and interpret the medication label;• follow the directions on the medication label correctly; and• accurately identify the camper for whom the medication is ordered.	
Demonstrate the appropriate and correct record keeping regarding medications given and/or self-administered.	
Demonstrate correct and accurate notations on the record if medications are not taken/given either by refusal or omission and when adverse reactions occur.	
Describe the proper action to be taken if any error is made in medication administration or if there is an adverse reaction possibly related to medication.	
Use resources appropriately, including the consultant, parent/guardian or emergency services when problems arise including: <ul style="list-style-type: none">• steps to follow;• when to call 911;• notification of parent/guardian and health care consultant; and• appropriate procedures that assure confidentiality.	

Comments:

Signatures:

Health Care Consultant

Name and Title: _____

Signature: _____

Date

Health Care Supervisor

Signature: _____

Date