# 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:

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| --- | --- | --- |
| Health Care Supervisor’s Name: |  | |
| Date of Assessment: |  |  |
| Medication Name(s):   * See attached list |  | |

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

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| --- | --- |
| **Checklist** | |
| **Steps to Follow:** | **Check** (**√**) |
| Demonstrate safe handling and proper storage of medication. |  |
| Demonstrate the ability to administer medication properly:   * 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:   * steps to follow; * when to call 911; * notification of parent/guardian and health care consultant; and * appropriate procedures that assure confidentiality. |  |

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| Comments: |

**Signatures:**

**Health Care Consultant**

Name and Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**Health Care Supervisor**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date