# Massachusetts Department of Public Health

# Medication Administration Competency Skill Checklist

# To be completed at the time the Health Care Supervisor (other than licensed medical professional) is assessed by the camp’s Health Care Consultant.

## Staff Information:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Health Care Supervisor  Name: |  | | |  |  |
|  |  | | |  |  |
| Date: |  |  |
|  |  |  |
| Medication Name: |  | | | | |

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

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Oral Liquid Other (please document):­­­­­­­­­­­­­­­

## Checklist:

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| **Steps to follow: √ (Check)**   |  |  | | --- | --- | | Identifies camper |  | | Asks camper how he/she feels |  | | Observes camper |  | | Reads medication administration plan |  | | Washes hands |  | | Checks label of medication |  | | Prepares medication properly |  | | Reads label of medication a 2nd time |  | | Reads label of medication a 3rd time and administer med correctly |  | | Replaces medication in cabinet or refrigerator |  | | Locks cabinet |  | | Documents in medication log |  |   Comments:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

## Signatures:

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| --- | --- | --- | --- |
| Health Care Consultant  Name and Title: |  |  |  |
|  |  |  |  |
| Signature: |  |  |  |
|  |  |  |  |

**Health Care**

**Supervisor**

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  |  |  |