Individual Specific Training/Delegation Form

Form to be reviewed with each certified DD personnel **BEFORE** administration of medication or HRA, updated when a new route of medication is received.

Client Name:_____ Identified by: Name Picture Other_____

Address or Facility:_____

Diagnosis/Health Care Information:_____

_____

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_____

Drug/Food Allergies:_____

Special Instructions – attach additional documentation as needed (where and how meds taken, task performed ie: meds taken with beverage or BP taken in left arm only)_____

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Emergency Meds: ☐Diastat ☐Epi-Pen ☐Glucagon ☐Other:_____

Emergency Medication Instruction (if applicable):_____

_____

_____

Medication Routes or HRA's performed (check all that apply) or Other:_____

☐Oral	☐Inhaler	☐Oxygen	☐Ostomy Care	☐Glucometer
☐Rectal	☐Nebulizer	☐Pulse Ox	☐Urine Drainage/empty	☐Insulin Injected
☐Vaginal	☐Nasal	☐CPap/BiPap	☐External Urinary Cath Care	☐Insulin Inhaled
☐Sublingual/Buccal	☐Vital Signs	☐Cough Assist	☐I&O	☐Insulin Pump
☐Eye (R or L)	☐Diastat	☐Percussion Vest	☐Specimen Collection	☐Glucagon
☐Ear (R or L)	☐Epi Pen	☐Oral Suction	☐Simple Dressing	☐G/J Tube
☐Topical	☐OTC Musculoskeletal		☐Compression Hose	☐Non-Insulin Injectables

****Trainer must also initial Updates column if changes are made. Signatures indicate observation was completed by designee.**

Date of IST or Delegation	**Staff Signature**	**Trainer Signature**	Updates/Changes (HRA or Mediation Route)	Staff Sign and Date

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Client Name:____

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Date IST or Delegation	**Staff Signature**	**Trainer Signature**	Updates/Changes (HRA or Mediation Route)	Staff Sign and Date