School Employee Volunteer Training Documentation

Emergency Seizure Rescue Medication

(One form per student listing ALL trained school employee volunteers)

STUDENT INFORMATION			
Student:	School Year:	School:	Grade/Teacher:
Parent:	Phone:	E-mail:	
Physician:	Phone:	Fax:	
School Nurse or Licensed Trainer:	Phone:	Fax:	

☐ Explanation and Discussion
- Individualized Healthcare Plan, and (not all students will have Section 504 or IEP)
  - Section 504 Accommodation Plan
  - IEP
- View training PPT and videos
- STARR

☐ Medication Administration
- Review Pertinent Medication Policy
- Medication Administration Training
- Emergency Seizure Rescue Medication Competency Check List
- Verbalization and demonstration of administration of Medication
- Passed skills competency

  ☐ Intranasal ☐ Rectal ☐ Other:_____
- Discussion of potential problems and expected outcomes

☐ Documentation

☐ CPR and First Aid Certification (not required if two or more other employees are trained as first responders at the school, <u>but HIGHLY recommended</u>)

The Trained School Employee Volunteers have:

- Reviewed the Individualized Healthcare Plan (IHP) and 504/IEP (if applicable) for the specific student listed above.
- Completed the required training program.
- Demonstrated competency in the described skills for the student listed above.
- Understands the need to maintain skills and will be observed on an ongoing basis by the trainer.
- Understands the need to complete an annual refresher training each year in order to remain a trained school employee volunteer.
- Has had the opportunity to ask questions and received satisfactory answers.

School Nurse/Licensed Trainers Name:	Signature:	Date:
Volunteer Trainee Name / Position:	Signature:	Date:
Volunteer Trainee Name / Position:	Signature:	Date:
Volunteer Trainee Name / Position:	Signature:	Date:

Copies to be kept in student's permanent files, with IHP / SMMO and must be updated annually.