Medication Skills Training

Center Name: _____ Nurses Name: _____ Date: _____

Name	Inhaler With / Without Spacer	EPI Pen	Nebulizer	Pills / Liquid

The staff above have successfully demonstrated the skills part of medication training.

Nurse Signature _____ Date: _____

Please email form to jheck@psesd.org for questions please call Janice Heck at 425-917-7727