**MEDICATION ADMINISTRATION FLOW SHEET (July – December)**

**(for Medicaid School-Based Services Documentation)**

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| --- | --- | --- |
| Name of LEA: | School: | Grade: |
| Student Name: | Date of Birth: | Medicaid #: | ICD-9 Code(s): |
| Name of Medication: | MD/NP/PA: |
| Date Begun: | Dose of medication (in mg): | Route: | Time(s): |
| Date of Change: | Dose: | Route: | Time(s): |
| Date of Change: | Dose: | Route: | Time(s): |

RN Review (Signature, Credentials, Title): Date:

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| Month | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** | **15** | **16** | **17** | **18** | **19** | **20** | **21** | **22** | **23** | **24** | **25** | **26** | **27** | **28** | **29** | **30** | **31** |
| July (time & initials) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Aug.**(time & initials)** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Sept.(time & initials) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | X |
| Oct.**(time & initials)** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Nov.**(time & initials)** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **X** |
| Dec.**(time & initials)** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Initials Full Name & Title Signature Date** (Keep current form with Medication Administration Authorization. File in student’s folder when complete.) | INSTRUCTION/CODES**X= Weekend / Non-Scheduled School Day A = Absent D/C=Discontinued D = Early Dismissal (left school before scheduled time)****N = No Medications/supplies available for procedure – Parent Notified (document on reverse side)****O = Medication/procedure Omitted (document reason on reverse side)****R = No Show/Student Refusal (document on reverse side)** |

NARRATIVE NOTES & REVIEW OF RESPONSE TO MEDICATION (Side 2 of Flow Sheet)

(TO BE COMPLETED AT LEAST WEEKLY BY THE RN, *with* UAP IF APPROPRIATE)

## STUDENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Date: Time: Comments: (response to med, side effects, reason for omission, etc.) RN Signature:

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| Documentation INSTRUCTIONS:* One form is needed for each different medication.
* Give medication within 30 minutes of time scheduled.
* Initial immediately in the box to indicate medication was given & time given.
* **Use pen for documentation, no markers or pencils.**
* Do not alter with “white out” or erasures. If you make an unintentional entry, mark through it with a single line & initial, date. Explain on Side 2
* If student does not take medication, use appropriate code and explain on notes page.
* Sign your full name once, on the front, the first time administered or performed.
* Sign your full name once, on the back, each first time you add comments on the narrative notes page.
 | GENERAL INSTRUCTIONS FOR ADMINISTERING MEDICATIONS:* Wash hands before assisting students.
* Review the 6 R’s to ensure safety each time: *right student, right medication, right dose, right time, right route, (W)rite- document*
* **Keep medications secured at all times.**
* Make two documented contacts with the parent/guardian to pick up expired or discontinued medications before disposing. Document disposal and have a witness.
* Once poured, do not leave medication unattended.
* Immediately report errors to parent, physician and RN. Complete Incident Report.
* Do not repeat medication if a student spits it out unless you are sure he did not retain any. Notify RN for further instructions.
* Do not repeat medication if student vomits. Notify parent.
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**MEDICATION ADMINISTRATION FLOW SHEET (January – June)**

**(for Medicaid School-Based Services Documentation)**

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| Name of LEA:  | School: | Grade: |
| Student name: | Date of Birth: | Medicaid #: | ICD-9 Code(s): |
| Name of Medication: | MD/NP/PA: |
| Date Begun: | Dose of medication (in mg): | Route: | Time(s): |
| Date of Change: | Dose: | Route: | Time(s): |
| Date of Change: | Dose: | Route: | Time(s): |

RN Review (Signature, Credentials, Title): Date:

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| Month | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** | **15** | **16** | **17** | **18** | **19** | **20** | **21** | **22** | **23** | **24** | **25** | **26** | **27** | **28** | **29** | **30** | **31** |
| Jan**(time & initials)** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Feb.**(time & initials** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **X** | **X** |
| March**(time & initials** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| April**(time & initials** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **X** |
| May**(time & initials** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| June**(time & initials)** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **X** |
| **Initials Full Name & Title Signature Date** (Keep current form with Medication Administration Authorization. File in student’s folder when complete.) | INSTRUCTION/CODES**X= Weekend / Non-Scheduled School Day A = Absent D/C=Discontinued D = Early Dismissal (left school before scheduled time)****N = No Medications/supplies available for procedure – Parent Notified (document on reverse side)****O = Medication/procedure Omitted (document reason on reverse side)****R = No Show/Student Refusal (document on reverse side)** |

**Nursing Services Documentation of Medication**

**For School-Based Medicaid Reimbursement**

**Note:** A separate sheet is required for each medication to be administered or procedure performed.

**Student Name:** Medicaid requires the student’s *legal name* to be on all service documentation.

**Date of Birth:** Enter the student’s date of birth. This is helpful in identification of the student for Medicaid billing.

**District/School:** Enter the school that student will be attending during the year. If student transfers, enter the name of the new school. Medicaid requires documentation of the place where the service was rendered. If provided any place other than the school listed, make a comment on side 2 of the form and state where it occurred. (home, field trip, etc.)

**ICD-9 Code:** Medicaid requires an ICD-9 diagnosis code for billing to support the medical need for the nursing service.

**Medication name:** Medicaid requires that documentation include a description of the service to be provided and at what frequency.

**MD/ NP/ PA:** Enter the student’s physician or other health care provider prescribing the service. Order must be attached and written on or before first date of medication given.

**Date and Time of Service:** Medicaid requires that service documentation include the date and time the service is provided.

**RN Review/Date:** The RN transcribing the order signs here and includes the date of the order review.

**Initials:** The individual administering the mediation must initial each time it is done to indicate that the service was provided.

 Side Two or Page Two

(To be Completed at Least Weekly by the RN, and UAP if Appropriate)

**Student’s reaction to medication: Complete NARRATIVE NOTES & REVIEIW OF RESPONSE TO MEDICATION** at least weekly. The RN completes with input from other caregiver, UAP, if appropriate. After administering the medication, evaluate the student’s response. If the student misses or refuses the dose, has an adverse reaction, or other untoward response, document as event occurs.

**Signature/Credentials:** The individual performing the service must sign the form and provide appropriate title or credentials the first time the service is rendered. Sign each time an entry is made on the Narrative Notes page.

**Codes:** The appropriate code must be entered in the day’s box when the service is not performed, or the medication not administered. The same code may be used in the *reaction* box. When indicated, or if (C) is entered, add an explanation on the continuation page, side 2.

NC DCFW/SACHU 5/2022