Health Certification Project
MEDICATION PASS RECORD

DIRECTIONS:

- *Medication passes must be evaluated by an R.N., L.P.N., or Pharmacist – C.M.A.'s may not evaluate medication passes for students.*
- *Medication passes on this record must be evaluated after the student has completed a minimum of 40 hours of training through an OSDH-Approved Program*
- *Students must pass medications to 20 consecutive individuals with 100% accuracy. All questions for all medications administered during a medication pass must be answered "Yes". For all "No" responses, the evaluator must explain the error(s) that occurred on the last page.*

Facility Where Med Passes Were Performed:		**City Where Facility is Located:**
Student Name:	**Evaluator's Name/Signature:**	**Result:** PASS FAIL

Actual Date/Time Medication Passed	Client Identifier *do not use full patient name	Name of Drug, Dosage of Drug, and Form of Drug Passed	Was client identification verified?	Was correct drug passed?	Was drug dosage correct?	Was the correct form of the drug passed?	Was the drug passed and documented correctly on the MAR?	I observed this medication pass. (Evaluator's Initials)
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	

Student Name:

Date/Time Medication Passed	**Client Identifier** *do not use full patient name	**Name of Drug, Dosage of Drug, and Form of Drug Passed**	**Was client identification verified?**	**Was correct drug passed?**	**Was drug dosage correct?**	**Was the correct form of the drug passed?**	**Was the drug passed and documented correctly on the MAR?**	**I observed this medication pass. (Evaluator's Initials)**
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	

Student Name:

Date/Time Medication Passed	Client Identifier *do not use full patient name	Name of Drug, Dosage of Drug, and Form of Drug Passed	Was client identification verified?	Was correct drug passed?	Was drug dosage correct?	Was the correct form of the drug passed?	Was the drug passed and documented correctly on the MAR?	I observed this medication pass. (Evaluator's Initials)
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	
			Yes No	Yes No	Yes No	Yes No	Yes No	

Student Name:

Documentation of Errors Observed on Medication Passes

Date/Time of Medication Pass	Client Identifier	Name of Medication Passed Incorrectly	Describe the error(s) made by the student:	Describe action taken: