Trainer/Date:

_____
_____
_____

POMONA UNIFIED SCHOOL DISTRICT

Medication Special Procedure Training Documentation for Unlicensed Assitive Personnel

School_____

Trained /Date:		**Dates trained/monitored for the school year of:**								
Print name	**Signature/Initial**	Oral meds	Inhaler	Blood glucose	Epi Pen	Glucogon	Diastat	Other:	Other:	Other:

The above district personnel acknowledge receiving training to provide the above services as indicated by the physician order and/or Pomona Unified School District guidelines.

School Nurse: _____