Champlain Community Services
512 Troy Ave, Suite 1 Colchester, VT 05446
655-0511/655-5207

MEDICATION DELEGATION RECORD

_____ _____
Trainer's Name Trainers Title
(must be RN, LPN or MD)

_____
Staff Name

Consumer Name : _____

Allergies: _____

Medication: _____

Dosage/ Frequency/ Route:_____

_____

I certify as the trainer listed above that I have met with the staff listed on this form (either in person or by telephone) and trained them on the administration of the medications listed.

_____ _____
Staff Signature Date

_____ _____
Trainer Signature Date

Additional Medications: _____

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