

Massachusetts Department of Public Health

Administering Medication for Diabetes Care at Medical Specialty Camps Test of Competency Checklist

To be completed at the time the individual authorized to administer medication for diabetes care at a medical specialty camp under 105 CMR 430.159(F) is assessed by the camp's Health Care Consultant for compliance with 105 CMR 430.160(I)(4).

Staff Information

Name: _____

Date of
Assessment: _____

| Checklist | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|
| Steps to Follow: | Check (v) |
| Demonstrates safe handling and proper storage of insulin, needles, auto-injectors, and pumps. | |
| Describe diabetes management for campers. | |
| Demonstrates ability to administer insulin properly via all relevant methods. | |
| Demonstrates an understanding of signs and symptoms of high or low blood sugar. | |
| Describes proper emergency action to be taken in response to cases of severely high or low blood sugar, insulin administration errors, or insulin refusals including: <ul style="list-style-type: none">• steps to follow;• administration of emergency medication, like glucagon;• when to call 911; and• notification of parents/guardian and health care consultant. | |
| Demonstrates appropriate and correct record keeping regarding use of insulin auto-injectors and pumps in medication log. | |
| Use resources appropriately, including the health care consultant, parent/guardian or emergency services. | |
| Demonstrates proper disposal of medical waste in accordance with 105 CMR 480.00: Minimum requirements for the management of medical or biological waste. | |
| <u>Comments:</u> _____ | |

Signatures:

Health Care Consultant

Name and Title: _____

Signature: _____

Date

Staff

Signature: _____

Date