



STATE OF MISSOURI
 DEPARTMENT OF HEALTH AND SENIOR SERVICES
LEVEL I MEDICATION AIDE EXAMINATION SCORE SHEET

<input type="checkbox"/> FULL COURSE (16 HOURS) <input type="checkbox"/> CHALLENGE				SSN		
STUDENT NAME (LAST, FIRST, MIDDLE, MAIDEN)				HOME TELEPHONE NO. ()		
STUDENT ADDRESS (STREET)		CITY	STATE	ZIP CODE	DATE OF BIRTH	
TRAINING AGENCY NAME (16 HOURS)			CLASS BEGIN DATE		CLASS END DATE	
TRAINING AGENCY NAME (WRITTEN EXAM)			1ST ATTEMPT DATE	BOOKLET NO.	INCORRECT NO. OF QUESTIONS	
TRAINING AGENCY NAME (WRITTEN EXAM)			2ND ATTEMPT DATE	BOOKLET NO.	INCORRECT NO. OF QUESTIONS	
TRAINING AGENCY NAME (PRACTICUM EXAM)			1ST ATTEMPT DATE		PASS/FAIL	
TRAINING AGENCY NAME (PRACTICUM EXAM)			2ND ATTEMPT DATE		PASS/FAIL	
COMPETENCY RECORD				DATE OF INSTRUCTION	COMPETENCY OBTAINED (✓)	INSTRUCTOR INITIALS
GENERAL PRINCIPLES						
1. WASH HANDS						
2. TAKE ORAL TEMPERATURE						
3. TAKE RECTAL TEMPERATURE						
4. TAKE AXILLARY TEMPERATURE						
5. COUNT RADIAL PULSE						
6. COUNT APICAL PULSE						
7. COUNT RESPIRATION						
8. MEASURE BLOOD PRESSURE						
9. PUT ON AND REMOVE DAILY CARE NON STERILE GLOVES						
DRUG CLASSIFICATIONS						
10. USE A DRUG REFERENCE BOOK						
PREPARATION AND ADMINISTRATION						
11. PREPARE, ADMINISTER, REPORT AND RECORD ORAL MEDICATIONS						
12. PREPARE, ADMINISTER, REPORT AND RECORD OPHTHALMIC MEDICATIONS						
13. PREPARE, ADMINISTER, REPORT AND RECORD OTIC MEDICATIONS						
14. PREPARE, ADMINISTER, REPORT AND RECORD TOPICAL MEDICATIONS						
15. PREPARE, ADMINISTER, REPORT AND RECORD ORAL METERED DOSE INHALER MEDICATIONS						
16. ADMINISTER OXYGEN BY NASAL CANNULA						
17. PREPARE, ADMINISTER, REPORT AND RECORD BUCCAL AND SUBLINGUAL MEDICATIONS						
18. PREPARE, ADMINISTER, REPORT AND RECORD TRANSDERMAL PATCHES						
19. PREPARE, ADMINISTER, REPORT AND RECORD AEROSOL/NEBULIZER MEDICATIONS						
20. PREPARE, ADMINISTER, REPORT AND RECORD NASAL MEDICATIONS						
21. PREPARE, ADMINISTER, REPORT AND RECORD VAGINAL MEDICATIONS						
22. PREPARE, ADMINISTER, REPORT AND RECORD RECTAL MEDICATIONS						
OVERALL						
23. RESPECTS RESIDENT RIGHTS						
1ST INSTRUCTOR SIGNATURE		LICENSE NO.		PRINTED LAST NAME		
2ND INSTRUCTOR SIGNATURE		LICENSE NO.		PRINTED LAST NAME		



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Sample

PRACTICUM RECORD

PRACTICUM EXAMINATION MUST NOT BE GIVEN UNLESS A PASSING SCORE IS ACHIEVED ON WRITTEN EXAMINATION. The practicum examination shall be done in an approved facility which shall include the preparation, administration and recording of medications administered to residents under the direct supervision of the instructor. **STUDENT MUST HAVE 100% on the Practicum Exam to be eligible for certification. 2nd attempt must be given within 90 days of 1st attempt.**

PRACTICUM EXAM-1ST ATTEMPT		SIMULATION ALLOWED	PASS	FAIL	PRACTICUM EXAM-2ND ATTEMPT		SIMULATION ALLOWED	PASS	FAIL
A. WASH HANDS			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	A. WASH HANDS				
B. PUT ON AND REMOVE GLOVES			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	B. PUT ON AND REMOVE GLOVES				
C. MEASURE VITAL SIGNS (TPR AND BP)			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	C. MEASURE VITAL SIGNS (TPR AND BP)				
D. COUNT APICAL PULSE			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	D. COUNT APICAL PULSE				
ADMINISTER MEDICATIONS-TO PASS EXAM STUDENT MUST ADMINISTER 10 (TEN) DIFFERENT MEDICATIONS WITH NO MORE THAN 5 (FIVE) BEING ORAL. CHOOSE FROM LIST ON FRONT (11.-22.) <i>#311-12</i>					ADMINISTER MEDICATIONS-TO PASS EXAM STUDENT MUST ADMINISTER 10 (TEN) DIFFERENT MEDICATIONS WITH NO MORE THAN 5 (FIVE) BEING ORAL. CHOOSE FROM LIST ON FRONT (11.-22.)				
1. <i>Route</i>	NAME: <i>NAME of med.</i>				1.		NAME:		
2.	NAME:				2.		NAME:		
3.	NAME:				3.		NAME:		
4.	NAME:				4.		NAME:		
5.	NAME:				5.		NAME:		
6.	NAME:				6.		NAME:		
7.	NAME:				7.		NAME:		
8.	NAME:				8.		NAME:		
9.	NAME:				9.		NAME:		
10	NAME:				10		NAME:		
E. RESPECTS RESIDENTS RIGHTS					E. RESPECTS RESIDENTS RIGHTS				
<input type="checkbox"/> APPROVED FOR CERTIFICATION IF NOT EXPLAIN					<input type="checkbox"/> APPROVED FOR CERTIFICATION IF NOT EXPLAIN				

We, the undersigned, hereby verify that the following student has successfully completed the Level I Medication Aide course of instruction and have satisfactorily passed the examination to qualify for certification meeting all requirement of Missouri 19 CSR 30-84.030.

TRAINING AGENCY ADMINISTRATOR/OWNER/OPERATOR/DIRECTOR SIGNATURE	PRINTED LAST NAME
1ST PRACTICUM EXAMINER SIGNATURE (SIGNATURE VERIFIES STUDENT COMPETENCE)	PRINTED LAST NAME
2ND PRACTICUM EXAMINER SIGNATURE (SIGNATURE VERIFIES STUDENT COMPETENCE)	PRINTED LAST NAME



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B. PUT ON AND REMOVE GLOVES				B. PUT ON AND REMOVE GLOVES			
C. MEASURE VITAL SIGNS (TPR AND BP)				C. MEASURE VITAL SIGNS (TPR AND BP)			
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1. NAME:				1. NAME:			
2. NAME:				2. NAME:			
3. NAME:				3. NAME:			
4. NAME:				4. NAME:			
5. NAME:				5. NAME:			
6. NAME:				6. NAME:			
7. NAME:				7. NAME:			
8. NAME:				8. NAME:			
9. NAME:				9. NAME:			
10. NAME:				10. NAME:			
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