

**Staff Sign In Sheet for Training**

Type of Training: led day training Date: 8/27/24

Please print and sign your name below

Julie Johnson Julie M Johnson 8/27/24

## Employee Training

Presenter: Shannon Rice, RN

Employee: Julie Johnson Date: 8/27/24

The above named staff member has received the following information:

- Review of nurse notification expectations and procedures
- EpiPen information and procedure
- General seizure training including types of seizures and seizure first aid
- Orientation to and location of HCS medication and health care policy and procedure manual
- Health care directives review
- VNS information and procedure
- Diabetes overview including signs & symptoms of hypo/hyperglycemia
- Diets & Nutrition

1. I fully understand the above information and am willing to assume the responsibility for performing the procedures.
2. I will perform the procedures according to written instructions.
3. I will notify the nurse or physician of problems or questions.

Staff signature: Julie Johnson  
Signature of Trainer: Shannon Rice RN

# GENERAL PAI SITE TRAINING (60DAY)

EMPLOYEE Julie Johnson DATE 8/27/24

LENGTH OF TRAINING 2 hours

THE STAFF MEMBER HAS RECEIVED THE FOLLOWING INFORMATION:

Yes No N/A

- |                                     |                          |                          |   |
|-------------------------------------|--------------------------|--------------------------|---|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Epilepsy/Seizures – VNS, protocols, first aid, report forms, rescue meds |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Epi-pen – purpose and use  |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. DNR/DNI – POLST  |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Diabetes – general overview, diet, meds                                  |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Other <u>Diets &amp; Nutrition</u>                                       |

The staff member has received information on all topics presented  
and has successfully verbalized/demonstrated any skills.

1. I fully understand the above information and am willing to assume responsibility for performing the any of the above training/procedures.
2. I will perform any procedure according to the instructions provided.
3. I will notify the nurse or healthcare provider of problems or questions.

Julie Johnson  
Staff Signature

[Signature]  
Nurse Signature

## Employee Training for Use of EpiPen

EMPLOYEE NAME Julie Johnson

DATE 8/27/24 LENGTH OF TRAINING 15 minutes

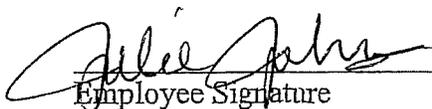
THE EMPLOYEE HAS RECEIVED THE FOLLOWING INFORMATION:

Yes No N/A

- |                                     |                          |                          |  |
|-------------------------------------|--------------------------|--------------------------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Signs and Symptoms of anaphylaxis                   |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Equipment necessary for procedure                   |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Specific protocol                                   |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Consequences if procedure not performed correctly   |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Symptoms and signs requiring physician notification |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Procedure for contacting nurse or doctor            |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Procedure for cleaning/replacing equipment          |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. Location of written procedure and protocol          |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. Purpose and effects of procedure                    |
| <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | 10. Other _____  |

**THE EMPLOYEE HAS SUCCESSFULLY DEMONSTRATED THEIR SKILL IN PERFORMING THIS PROCEDURE.**

1. I fully understand the above information and am willing to assume the responsibility for performing the procedure.
2. I will perform the procedure according to the written instructions.
3. I will notify the nurse or physician of problems or questions.

  
Employee Signature

  
Nurse Signature

# Employee Training for Vagus Nerve Stimulation (VNS)

EMPLOYEE NAME Julie Johnson

DATE 8/27/24 LENGTH OF TRAINING 15 minutes

THE EMPLOYEE HAS RECEIVED THE FOLLOWING INFORMATION:

Yes No N/A

- |                                     |                          |                          |   |
|-------------------------------------|--------------------------|--------------------------|---|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. Purpose and effects of procedure                     |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Equipment necessary for procedure                    |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Specific protocol                                    |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4. Symptoms and signs requiring physician notification  |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. Consequences if procedure is not performed correctly |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. Information about contacting nurse or doctor         |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. Procedure for cleaning/replacing equipment           |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. Location of written procedure and protocol           |
| <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | 9. Other _____  |

**THE EMPLOYEE HAS SUCCESSFULLY DEMONSTRATED THEIR SKILL IN PERFORMING THIS PROCEDURE.**

1. I fully understand the above information and am willing to assume the responsibility for performing the procedure.
2. I will perform the procedure according to the written instructions.
3. I will notify the nurse or physician of problems or questions.

Julie Johnson  
Employee Signature

[Signature]  
Nurse Signature