**Form 8**

***Staff Training Record***

***Administration of Medicine/ Medical Support***

CORPORATE HEALTH & SAFETY | VERSION 4.05 | June 2023

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of school/setting** |  | | | |
| **Name** |  | | | |
| **Type of training received** |  | | | |
| **Date of training completed** |  |  |  |  |
| **Training provided by** |  | | | |
| **Profession and title** |  | | | |

|  |
| --- |
| **For Trainer** |

I confirm that [name of member of staff] has received the training detailed above and is competent to carry out any necessary treatment. I recommend that the training is updated [please state how often].

|  |  |
| --- | --- |
| **Trainer’s signature** |  |
| **Print Name** |  | **Date** |  |

|  |
| --- |
| **For Staff** |

I confirm that I have received the training detailed above.

|  |  |
| --- | --- |
| **Staff signature** |  |
| **Print Name** |  | **Date** |  |
| **Suggested review date** |  |