**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** |       |

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| --- |
| **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** |       |