**Staff training record – administration of medicines**

Name of school/setting: --------------------------------------------------------------------------------------------

Name: --------------------------------------------------------------------------------------------

Type of training received: --------------------------------------------------------------------------------------------

Accreditation (where appropriate) --------------------------------------------------------------------------------------

Date of training completed: --------------------------------------------------------------------------------------------

Training provided by: --------------------------------------------------------------------------------------------

Profession and title: --------------------------------------------------------------------------------------------

I confirm that -------------------------------------------------------- (name of member of staff) has received the training detailed above and is competent to carry out any necessary treatment covered by it.

I recommend that the training is updated -------------------------------------- (please state how often).

Trainer’s signature: ----------------------------------------------------------- Date: -----------------------------------

I confirm that I have received the training detailed above.

Staff signature: ----------------------------------------------------------------- Date: -----------------------------------

Suggested review date: ------------------------------------------------------