Staff Training Record – Administration of Medicines

Name of school/setting	
Name	
Type of training received	
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. I recommend that the training is updated by…….(inset date).

Trainer's signature _____

Date _____

I confirm that I have received the training detailed above.

Staff signature _____

Date _____