FORM 8
ADMINISTRATION OF PRESCRIBED MEDICINE
STAFF TRAINING RECORD

Name of school/setting	
Name of staff member	
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/reviewed ..... (please state how often).

Trainer's signature	Date

I confirm that I have received the training detailed above.

Staff signature	Date