Staff/Host Training Record – administration of medicines

Name of College	
Name of staff/host	
Type of training received	
Date of training completed	
Training provided by	
Profession and title of trainer	

I confirm that _____[name of member of staff/host] has received the training detailed above and is competent to carry out any necessary treatment. I recommend that the training is updated _____[date].

Trainer's signature _____

Date _____

I confirm that I have received the training detailed above and agree to administer medications in line with this training to the below student/s.

Student	Commencement Date

Staff/Host signature _____

Date _____

Suggested review date _____

Student/s requiring above named medication: