# Staff training record

## Health / medical training for a child with a Health Care Plan

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| --- | --- |
| Name of school/setting: |  |
| Name of child: |  |
| Date of Health Care Plan identifying the need for training: |  |
| Training provided by: |  |
| Profession and title of the trainer: |  |
| Date of training completed: |  |
| Date of training needed to be reviewed: |  |

Please sign and date to confirm you have attended and completed the training above:

|  |  |  |
| --- | --- | --- |
| Staff member name | Date: | Signature |
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**Please note that this is a record of the training received to meet the needs of a child on a Health Care Plan and is NOT a certificate of training. If this is required by your insurance company, please ensure that you receive a certificate from the health professional delivering the training.**