



SPECIALIZED PROCEDURE TRAINING

CENTRAL VALLEY HEALTH DISTRICT

Name of Student _____ Today's Date _____

School _____ School Year _____

Name of Medical Procedure _____

Brief description of need and parent's request:

Name of staff member/s receiving training:

Name of parent providing training: _____

Name of school nurse who is present to provide medical consultation regarding this procedure

Brief description of training:

1. _____
2. _____
3. _____
4. _____

This is to certify that the parent listed below has provided the training and the staff names listed have demonstrated competency in the above procedure for: _____.

(Student's name)

Date _____

Acknowledge: *(Signatures)*

Parent _____

Principal _____

Staff member/s _____

Staff member/s _____

Staff member/s _____

Staff member/s _____

Staff member/s _____

Staff member/s _____

Staff member/s _____

Staff member/s _____

Staff member/s _____

Staff member/s _____

Staff member/s _____

Staff member/s _____

Date of required training/retraining _____