



GRIMSDYKE SCHOOL

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Headteacher: Mr's B Bhudia
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PARENTAL CONSENT FORM ADMINISTRATION OF MEDICATION IN SCHOOL

Please write clear instructions for each medication

| | <u>Name of medicine</u> | <u>Medical condition it is related to</u> | <u>Dosage</u> | <u>Time(s) to be administered</u> | <u>Tick to stay at school</u> |
|---|-------------------------|---|---------------|-----------------------------------|-------------------------------|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |

I _____ (print your name) consent to administration of the above medication to my child:

Childs Name: _____ Class: _____ Date of Birth: _____

Signed (Parent/Guardian) _____ Date: _____

Daytime tel: _____

The school will take all reasonable care to ensure that medication is administered as outlined above.

LEARNING AND ACHIEVING TOGETHER

