INDEPENDENT USE OF ASTHMA, ALLERGY & EMERGENCY MEDICATION

Date: ______________________________

Child's Name: ______________________________ **Program:** ________________

I, __________________________, parent/guardian of __________________________ give
(Name of Parent/Guardian) (Name of Child)

my permission for _________________________ to carry his/her own asthma, allergy and/or
(Name of Child)

emergency medications and to self-administer this medication without direction from the staff of Rockcliffe Child Care Centre.

I confirm that Rockcliffe Child Care Centre will have no responsibility for this medication, the manner in which it is administered or keeping records of the amount administered.

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(Signature of Parent/Guardian)