

IMMACULATE HEART ACADEMY STUDENT HEALTH FORMS

All forms must be completed between May 1 and September 1.

Fall Athletes must be submitted by August 1.

Physical exams completed outside of this date range will not be accepted.

Please upload all forms to the applicant portal

Required for ALL Students

- **Annual Physical Exam (pg. 2)**
Exam date must be between May 1 and September 1
- **Medication Authorization Form (pg. 3)**
All medications must be kept in the nurse's office. Students may not carry medications at school.
 - Exceptions: EpiPen and inhaler with physician approval
- **Allergy/Asthma Action Plans (pgs. 4–7), if applicable**
Physician must indicate if the student is permitted to self-carry medication

IMPORTANT NOTE: For Student Athletes Only

In addition to the mandatory physical, all athletes are required to submit a Medical Eligibility Form. This form is not included in this packet and must be submitted separately through Arbiter Sports Registration before each season in which the student participates in a sport.

The Medical Eligibility Form is available in the athletics section of ihanj.com and within Arbiter Sports Registration.

Please keep an electronic copy (PDF) of the Medical Eligibility Form for your records.

Health Updates

Parents/guardians should notify the school nurse of any new injuries, surgeries, diagnoses, or significant health changes during the school year.

Last Name: _____ First Name: _____ Class of: _____

**UNIVERSAL
CHILD HEALTH RECORD**

Endorsed by: American Academy of Pediatrics, New Jersey Chapter
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

| | | | |
|---|--|---|----------------------|
| Child's Name (Last) | (First) | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth / / |
| Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | If Yes, Name of Child's Health Insurance Carrier | | |
| Parent/Guardian Name | Home Telephone Number () - | Work Telephone/Cell Phone Number () - | |
| Parent/Guardian Name | Home Telephone Number () - | Work Telephone/Cell Phone Number () - | |

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date This form may be released to WIC.
 Yes No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

| | | |
|--|---|----------|
| Date of Physical Examination: | Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Abnormalities Noted: | Weight (must be taken within 30 days for WIC) | |
| | Height (must be taken within 30 days for WIC) | |
| | Head Circumference (if <2 Years) | |
| | Blood Pressure (if ≥3 Years) | |
| IMMUNIZATIONS | <input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____ | |
| MEDICAL CONDITIONS | | |
| Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns: | <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached | Comments |
| Medications/Treatments • List medications/treatments: | <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached | Comments |
| Limitations to Physical Activity • List limitations/special considerations: | <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached | Comments |
| Special Equipment Needs • List items necessary for daily activities | <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached | Comments |
| Allergies/Sensitivities • List allergies: | <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached | Comments |
| Special Diet/Vitamin & Mineral Supplements • List dietary specifications: | <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached | Comments |
| Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns: | <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached | Comments |
| Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for: | <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached | Comments |

PREVENTIVE HEALTH SCREENINGS

| Type Screening | Date Performed | Record Value | Type Screening | Date Performed | Note if Abnormal |
|--|----------------|--------------|----------------|----------------|------------------|
| Hgb/Hct | | | Hearing | | |
| Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous | | | Vision | | |
| TB (mm of Induration) | | | Dental | | |
| Other: | | | Developmental | | |
| Other: | | | Scoliosis | | |

I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.

Name of Health Care Provider (Print) _____ Health Care Provider Stamp: _____

Signature/Date _____

Last Name: _____ First Name: _____ Class of: _____

MEDICATION AUTHORIZATION FORM

This form is required for **prescription or over-the-counter medication** administered by school nurse or trained delegate.

Student Name: _____ **Date of Birth:** _____

Daily Medication(s) taken at home not listed below: _____

Over-the-Counter Medication Authorization *Please indicate all medications to be administered at school*

Acetaminophen 325mg _____ 1 tablet _____ 2 tablets as needed for fever/pain/menstrual cramps every 4-6 h
Acetaminophen 500mg _____ 1 tablet _____ 2 tablets as needed for fever/pain/menstrual cramps every 6 h
Ibuprofen 200mg _____ 1 tablet _____ 2 tablets as needed for fever/pain/menstrual cramps every 4-6 h
Benadryl 25mg _____ 1 tablet _____ 2 tablets as needed for allergies/allergic reaction every 4-6 h
Benadryl 25mg/5ml _____ 5ml _____ 10ml as needed for allergies/allergic reaction every 4-6 h

Prescription Medication Authorization *To be completed by the doctor if applicable*

Medication Name #1: _____ **Dose:** _____ **Route:** _____

Diagnosis: _____ **Frequency:** _____

Possible Side Effects: _____

Start Date: _____ **End Date:** _____

Medication Name #2 : _____ **Dose:** _____ **Route:** _____

Diagnosis: _____ **Frequency:** _____

Possible Side Effects: _____

Start Date: _____ **End Date:** _____

Healthcare Provider Name(println): _____ **Date:** _____

Healthcare Provider's Signature: _____ **Office Stamp:** _____

I have read and understand Immaculate Heart Academy's policy for the administration of the medications listed. I authorize the nurse or unlicensed assistive person (delegate) trained by the nurse and/or school physician when appropriate, to administer the above medication/procedure, including the emergency administration of epinephrine by pre-filled auto injector mechanism if ordered by the above name healthcare professional, to my daughter during school hours and at times when my child is participating in school-related events. I have been informed and understand that Immaculate Heart Academy, school physician, nurse, any trained or other school employees or agents shall incur no liability. I hereby indemnify and hold harmless the school, school physician, nurse, any trained delegate, and other school employees or agents as well as the Archdiocese of Newark, local school district, its Board of Education, and Bergen County Department of Health Services and its employees or agents against all claims arising from the administration of the listed medication or procedure. I consent to the communication between the school nurse or administrators and the prescribing healthcare professional to ensure the safe administration of the listed medication. I consent to this information being shared on a confidential basis with teachers/chaperones for school-sponsored activities. I hereby consent to the administration of above listed medication as ordered by a healthcare professional or school physician by the trained delegate(s).

Parent/Guardian Signature: _____ **Date:** _____

VALID FOR ONE (1) SCHOOL YEAR

Last Name: _____ First Name: _____ Class of: _____

Asthma Treatment Plan – Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)



(Please Print)

| | | |
|--------|---------------------------------|-------------------|
| Name | Date of Birth | Effective Date |
| Doctor | Parent/Guardian (if applicable) | Emergency Contact |
| Phone | Phone | Phone |

HEALTHY (Green Zone)



You have **all** of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above _____

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

| MEDICINE | HOW MUCH to take and HOW OFTEN to take it |
|---|--|
| <input type="checkbox"/> Advair® HFA <input type="checkbox"/> 45, <input type="checkbox"/> 115, <input type="checkbox"/> 230 _____ | 2 puffs twice a day |
| <input type="checkbox"/> Aerospan™ _____ | <input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day |
| <input type="checkbox"/> Alvesco® <input type="checkbox"/> 80, <input type="checkbox"/> 160 _____ | <input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day |
| <input type="checkbox"/> Dulera® <input type="checkbox"/> 100, <input type="checkbox"/> 200 _____ | 2 puffs twice a day |
| <input type="checkbox"/> Flovent® <input type="checkbox"/> 44, <input type="checkbox"/> 110, <input type="checkbox"/> 220 _____ | 2 puffs twice a day |
| <input type="checkbox"/> Qvar® <input type="checkbox"/> 40, <input type="checkbox"/> 80 _____ | <input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day |
| <input type="checkbox"/> Symbicort® <input type="checkbox"/> 80, <input type="checkbox"/> 160 _____ | <input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day |
| <input type="checkbox"/> Advair Diskus® <input type="checkbox"/> 100, <input type="checkbox"/> 250, <input type="checkbox"/> 500 _____ | 1 inhalation twice a day |
| <input type="checkbox"/> Asmanex® Twihaler® <input type="checkbox"/> 110, <input type="checkbox"/> 220 _____ | <input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day |
| <input type="checkbox"/> Asmanex® Diskus® <input type="checkbox"/> 50 <input type="checkbox"/> 100 <input type="checkbox"/> 250 _____ | 1 inhalation twice a day |
| <input type="checkbox"/> Pulmicort Flexhaler® <input type="checkbox"/> 90, <input type="checkbox"/> 180 _____ | <input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day |
| <input type="checkbox"/> Pulmicort Respules® (Budesonide) <input type="checkbox"/> 0.25, <input type="checkbox"/> 0.5, <input type="checkbox"/> 1.0 _____ | 1 unit nebulized <input type="checkbox"/> once or <input type="checkbox"/> twice a day |
| <input type="checkbox"/> Singulair® (Montelukast) <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 10 mg _____ | 1 tablet daily |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> None _____ | |

Remember to rinse your mouth after taking inhaled medicine. _____ puff(s) _____ minutes before exercise.

CAUTION (Yellow Zone)



You have **any** of these:

- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other: _____

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from _____ to _____

Continue daily control medicine(s) and ADD quick-relief medicine(s).

| MEDICINE | HOW MUCH to take and HOW OFTEN to take it |
|---|---|
| <input type="checkbox"/> Albuterol MDI (Pro-air® or Proventil® or Ventolin®) _____ | 2 puffs every 4 hours as needed |
| <input type="checkbox"/> Xopenex® _____ | 2 puffs every 4 hours as needed |
| <input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg _____ | 1 unit nebulized every 4 hours as needed |
| <input type="checkbox"/> Duoneb® _____ | 1 unit nebulized every 4 hours as needed |
| <input type="checkbox"/> Xopenex® (Levalbuterol) <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg _____ | 1 unit nebulized every 4 hours as needed |
| <input type="checkbox"/> Combivent Respimat® _____ | 1 inhalation 4 times a day |
| <input type="checkbox"/> Increase the dose of, or add: | |
| <input type="checkbox"/> Other _____ | |

• If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.

EMERGENCY (Red Zone)



Your asthma is getting worse fast:

- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other: _____

And/or Peak flow from _____ to _____ below

Take these medicines NOW and CALL 911. Asthma can be a life-threatening illness. Do not wait!

| MEDICINE | HOW MUCH to take and HOW OFTEN to take it |
|---|---|
| <input type="checkbox"/> Albuterol MDI (Pro-air® or Proventil® or Ventolin®) _____ | 4 puffs every 20 minutes |
| <input type="checkbox"/> Xopenex® _____ | 4 puffs every 20 minutes |
| <input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg _____ | 1 unit nebulized every 20 minutes |
| <input type="checkbox"/> Duoneb® _____ | 1 unit nebulized every 20 minutes |
| <input type="checkbox"/> Xopenex® (Levalbuterol) <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg _____ | 1 unit nebulized every 20 minutes |
| <input type="checkbox"/> Combivent Respimat® _____ | 1 inhalation 4 times a day |
| <input type="checkbox"/> Other _____ | |

Triggers

Check all items that trigger patient's asthma:

- Colds/flu
- Exercise
- Allergens
 - Dust Mites, dust, stuffed animals, carpet
 - Pollen - trees, grass, weeds
 - Mold
 - Pets - animal dander
 - Pests - rodents, cockroaches
- Odors (Irritants)
 - Cigarette smoke & second hand smoke
 - Perfumes, cleaning products, scented products
 - Smoke from burning wood, inside or outside
- Weather
 - Sudden temperature change
 - Extreme weather - hot and cold
 - Ozone alert days
- Foods:
 - _____
 - _____
 - _____
- Other:
 - _____
 - _____
 - _____

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

REVISED MAY 2017

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Make a copy for parent and for physician file, send original to school nurse or child care provider.

Please complete that student may self carry

Asthma Treatment Plan – Student Parent Instructions

The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.



- Parents/Guardians:** Before taking this form to your Health Care Provider, complete the top left section with:
 - Child's name
 - Child's doctor's name & phone number
 - Child's date of birth
 - An Emergency Contact person's name & phone number
 - Parent/Guardian's name & phone number
- Your Health Care Provider will** complete the following areas:
 - The effective date of this plan
 - The medicine information for the Healthy, Caution and Emergency sections
 - Your Health Care Provider will check the box next to the medication and check how much and how often to take it
 - Your Health Care Provider may check "OTHER" and:
 - ❖ Write in asthma medications not listed on the form
 - ❖ Write in additional medications that will control your asthma
 - ❖ Write in generic medications in place of the name brand on the form
 - Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow
- Parents/Guardians & Health Care Providers together** will discuss and then complete the following areas:
 - Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
 - Child's asthma triggers on the right side of the form
 - Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form
- Parents/Guardians:** After completing the form with your Health Care Provider:
 - Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
 - Keep a copy easily available at home to help manage your child's asthma
 - Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

Parent/Guardian Signature

Phone

Date

FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

I do request that my child be **ALLOWED** to carry the following medication _____ for self-administration in school pursuant to N.J.A.C.:6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

I **DO NOT** request that my child self-administer his/her asthma medication.

Parent/Guardian Signature

Phone

Date



Pediatric/Adult Asthma Coalition

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Sponsored by
AMERICAN LUNG ASSOCIATION
 IN NEW JERSEY

Last Name: _____ First Name: _____ Class of: _____



FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergic to: _____

Weight: _____ lbs. Asthma: Yes (higher risk for a severe reaction) No

PLACE
PICTURE
HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:

SEVERE SYMPTOMS



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue or lips



SKIN

Many hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion



1. INJECT EPINEPHRINE IMMEDIATELY.

2. Call 911. Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
- Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: 0.1 mg IM 0.15 mg IM 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

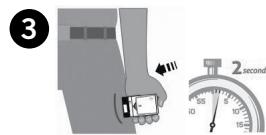
Last Name: _____ First Name: _____ Class of: _____



FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

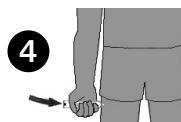
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



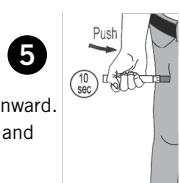
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENAClick®, USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS)

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____

NAME/RELATIONSHIP: _____ PHONE: _____