Registering a New 1st Grade student that did NOT attend Moss School Kindergarten

Registration for 1st grade students will take place at Campbell School, 24 Durham Ave
March 18 – 9:00AM -11:00AM
Or
March 19 – 12:00PM – 2:00PM
No appointment required

Please bring the following documents to your registration;

☐ Campbell Forms Completed - see below
☐ Original Birth Certificate
☐ Last Progress Report from Kindergarten
☐ Two proofs of Metuchen Residency:
  ○ Current Property Tax Bill or Current Lease (month to month not accepted)
  ○ 2 Current Utility Bills - Driver's License
☐ Universal Health Record
☐ Immunization Records
☐ Please complete ONLINE REGISTRATION in addition to Printed forms below
METUCHEN SCHOOL DISTRICT
Metuchen Board of Education
16 Simpson Place
Metuchen, NJ 08840

Campbell School
Edward C. Porowski
Principal

5II2 ENTRANCE AGE

Metuchen School District requires that children entering first grade must be six years old by October 1st 2020

BUS TRANSPORTATION

If your child is eligible for bus transportation for the school year, please register below.

Contact:

Metuchen Board of Education
Transportation Department
16 Simpson Place
Metuchen, NJ 08840

732-321-8700 ext. 1010
CAMPBELL SCHOOL
"A Great Place to Learn"
Metuchen, NJ 08840

CAMPBELL SCHOOL EMERGENCY FORM

Teacher __________________ Grade _______ School Year ________

Dear Parents/Guardians: It is often necessary to contact the home during school hours because of an accident, sudden illness or emergency closing. Please provide us with the information requested below to be used in an emergency.

Child's Name ___________________________ Birth Date ________________

Home Address ___________________________ (tuition student yes or no)

Home Phone # ___________________________ Cell Phone #’s ___________________________

Email Addresses (work/home) __________________________________________________________________________

Parent One/Guardian ________________________________________________________________________________

Business Address ____________________________________________________________________________________

Parent Two/Guardian ________________________________________________________________________________

Business Address ____________________________________________________________________________________

Phone # ____________________

Phone # ____________________

* Divorced or Separated? If yes, with whom is the child living with and are there any legal restrictions we should know about? ________________________________________________________________________________________________

* Other Parent’s Home Address & Phone # ____________________________________________________________________

* Does child have Health Insurance?

Yes _____ If yes, name of insurance company ____________________________________________________________________________

No _____ NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 1-800-701-0710 or visit www.njfamilycare.org to apply online.

You may release my name and address to the NJ FamilyCare Program to contact me about health insurance. Signature __________________________________________________________________________

Printed Name ________________________________ Date ________________

Please List All Other Children in the Family and Their Birth Dates:

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

Please fill in both sides of this form!
CAMPBELL SCHOOL EARLY DISMISSAL INFORMATION

Student's Name ___________________ Homeroom Teacher ___________________

*In case of an EXTREME emergency or sudden illness and the school is not able to reach you, whom do you designate to assume the responsibility for your child? PLEASE DESIGNATE SOMEONE IN THE IMMEDIATE AREA!

If you can’t be reached, one of your emergency contacts will be notified.

Please note that in the event you can’t be reached and school personnel call your family doctor, you will assume full responsibility for costs of his/her services.

Contact #1 Name ___________________ Phone: ___________________
Cell: ___________________ Relationship to child: ___________________

Contact #2 Name ___________________ Phone: ___________________
Cell: ___________________ Relationship to child: ___________________

Contact #3 Name ___________________ Phone: ___________________
Cell: ___________________ Relationship to child: ___________________

Parent/Guardian Signature ____________________________________________

**In the event of a possible emergency early dismissal you will be notified by the Honeywell Alert System.**

*PLEASE MAKE SURE THAT YOU HAVE REGISTERED ALL OF YOUR CONTACT INFORMATION ON THE HONEYWELL ALERT SYSTEM.*

*STUDENTS MAY NOT REMAIN AT SCHOOL IN THE EVENT OF AN EARLY DISMISSAL*

The Metuchen Public School District requires a signed acknowledgement indicating that you have viewed the following items: a district and school calendar, a student handbook, and Policy #8601 Pupil Supervision after School Dismissal. These documents are available on the District and Campbell School webpage.

Parent/Guardian Signature: ___________________________ Date: __________

PHOTOGRAPHS AND VIDEOTAPEs

Frequently, teachers will take both photographs and videotapes of class activities for use in books and displays, as well as in newspaper articles regarding school projects. Please sign below, granting Campbell School permission to use the photographs and videos in these ways.

I, ___________________________ give Campbell School permission to

( Parent/guardian printed name )

include my child, ___________________________ in school photos or videotapes.

(Child's printed name)

Parent/Guardian Signature ____________________________________________
STUDENT REGISTRATION FORM

STUDENT'S NAME: ____________________________

First    middle    last

Address (not P.O. Box): ____________________________

Home phone: _______________ Sex (male/female): _____ Hair & Eye color: ______

Date of Birth: ___________ Place of Birth: _________________

Name & Address of Previous School: ________________________________

Any Previous Special Education Programs? ________ Remedial Programs? _______

Any Previous Retention? ________ Speech referrals? ________ ESL Needed? ________

Language Spoken in Home: English ______ Spanish ______ Other ________

Child's Ethnicity: American Indian ______ Asian ______ Black ______ Hispanic ______ White ______

Health Comments: Glasses ______ Hearing ______ Seizures ______ Asthma ______ Allergies ______

Family Information:

Parent One Name: ____________________________ Parent Two Name: ____________________________

Employer: ____________________________ Employer: ____________________________

Work Phone: ____________________________ Work Phone: ____________________________

Please list all other family members living with you: ____________________________

________________________________________

CHILD RESIDES WITH:

Both Parents ________ Other _________

Revised 1/2009
AUTHORIZATION TO RELEASE RECORDS

Today's Date: __________________________

Student Name: __________________________________________

Last Grade Attended: _____  Last Date Attended: ________________

Name and Address of School Last Attended: _________________________

Telephone (former school): ________________________________

I hereby authorize you to forward all documents pertaining to the above student:
• Cumulative Records
• Health Records (immunization form A-45, etc.)
• Guidance Records (Standardized Test results, attendance records)
• Child Study Team Records (IEP's, Learning Evaluations, Annual Reports, Speech, ESL)
• Free/Reduced Lunch Form
• Other ______________________________________

Signature of parent/guardian ________________________________
Signature of school official ________________________________

Please forward all records to: Campbell School
24 Durham Avenue
Metuchen, NJ 08840
Attention: Main Office
# METUCHEN PUBLIC SCHOOLS
## CAMPBELL SCHOOL
### FAMILY PHYSICIAN’S REPORT

<table>
<thead>
<tr>
<th>VACCINE TYPE</th>
<th>DISEASE TYPE</th>
<th>1ST DOSE</th>
<th>2ND DOSE</th>
<th>3RD DOSE</th>
<th>4TH DOSE</th>
<th>5TH DOSE</th>
<th>6TH DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria, Tetanus, Pertussis-DTP</td>
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<td>If DT or D, check here</td>
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<tr>
<td>Oral Polio Vaccine (OPV)</td>
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<tr>
<td>Salk Vaccine, (IPV) check here</td>
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<tr>
<td>Measles:</td>
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<tr>
<td>Mumps</td>
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<tr>
<td>Rubella</td>
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<tr>
<td>Varicella</td>
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</tr>
</tbody>
</table>

**Other:**
- Hep B
- Hib

## PHYSICAL EXAMINATION

<table>
<thead>
<tr>
<th>Ht.</th>
<th>Wt.</th>
<th>Abdomen</th>
<th>Operations or Injuries</th>
<th>Year</th>
</tr>
</thead>
<tbody>
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</tbody>
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<table>
<thead>
<tr>
<th>Ears (Otoscopy)</th>
<th>GenitoUrinary</th>
<th>Urinalysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td>Structural</td>
<td></td>
</tr>
<tr>
<td>Lymph Glands</td>
<td>Orthopedic</td>
<td>Scoliosis</td>
</tr>
<tr>
<td>Thyroid</td>
<td>Feet</td>
<td></td>
</tr>
<tr>
<td>Nose</td>
<td>Skin (Non Comm.)</td>
<td>Congenital Defects</td>
</tr>
<tr>
<td>Throat</td>
<td>Nutrition</td>
<td></td>
</tr>
<tr>
<td>Teeth/Mouth</td>
<td>Nervous System</td>
<td></td>
</tr>
<tr>
<td>Heart B/P</td>
<td>Speech</td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TB Screening (Mantoux Test)</th>
<th>Tested</th>
<th>Read</th>
<th>Result (MM)</th>
</tr>
</thead>
</table>

Is this child capable of carrying a full program of school work, including physical education and athletics?

YES_______ NO________

Should the school program be modified to meet the needs of this child? YES_______ NO________

Is this child taking any medication? YES_______ NO________

Please indicate type and reason:

Physician (PLEASE PRINT)_________________________  Physician (SIGNATURE)_________________________  
or  
Physician (SIGNATURE)_________________________  or  
Nurse Practitioner_________________________  Nurse Practitioner_________________________  
Date
ANNUAL HEALTH UPDATE FORM-RETURN TO NURSE

Dear Parents/Guardians:

Please fill out both sides of this form. This information is necessary to update your child’s health record and is useful in an emergency.

CHILD'S NAME: ___________________________ GRADE: ______________

HOMEROOM: ___________________________ SCHOOL: ________________________

A. Medical History: Check the ones that apply to your child and describe under the comment section.

- ADD/ADHD/PDD
- Asthma **
- Behavioral problems
- Bleeding disorder
- Bowel or digestive problem
- Cerebral Palsy
- Diabetes
- Emotional disorder
- Kidney/urinary problem
- Muscular disorder
- Neurological disorder
- Orthopedic problems
- Seizure disorder
- Skin condition

Comments: ____________________________________________________________

List allergies to medications: ____________________________________________

Any other allergies: ____________________________________________________

If allergies to foods/bees, do they require an Epi-pen® (if yes, see Nurse)?

Has your child been tested by an allergist (skin prick test or lab work)? Yes or No

Does your child get allergy shots: Yes No If so, how often?

Is your child allergic to bee/wasp stings? Yes or NO If so, what type of reaction did the child have (local swelling at site; difficulty breathing)? SEE NURSE IF CARRY EPIPEN

Is child on any medication? Yes No If so, what?

Dosage __________________________ Reason for med? __________________________

Any other chronic health problems/concerns that may affect learning:

__________________________

Does your child have any activity restrictions (PE, recess)?

A doctor’s note is needed if your child has any activity restrictions (ex. From asthma, heart conditions, allergies, or any other disease/injury). It is the parent’s responsibility to provide the school with the doctor’s excuse.

OVER
Does your child have any assistive devices (hearing aide, brace, etc.)? __________________________

Any hearing loss? _______ If so, which ear? __________________________

Is special seating needed in the classroom? __________________________

Does your child wear (circle) glasses / contact lenses? Date of last prescription ________________

Date of last physical ________________ Physician __________________________

**If any immunizations were received please provide the school nurse with a certificate of immunization from the physician.

Date of last dental exam ________________ Dentist __________________________

Orthodontic braces on teeth? __________________________

Please list any surgeries, injuries, accidents, or childhood illness (chicken pox, etc.) requiring medical attention along with any pertinent information (date, doctor’s name, hospital, etc) this past year.

________________________________________

SCHOOL MEDICATION POLICY: If your child requires medication in school, a written physician’s order is required per NJ State law. No medication may be carried in school by a student; this applies to medications “over the counter” as well. The only exceptions are for those students with asthma inhalers and Epi-pens whose order specifies that they may “self administer”. All medications must be delivered to the school health office by the parent/guardian with the physician’s original order and written parental permission (forms are available in the office). All prescription and nonprescription medications must be in their original bottles/boxes. Your pharmacist can provide you with a labeled school supply bottle/box.

*** Please see the School Nurse for an allergy action or food allergy care plan if your child requires (or carries) an inhaler or Epi-pen® at school.

This information is confidential and will only be shared to appropriate Metuchen school personnel with your consent, to help protect and promote your child’s health and welfare.

Parent/Guardian Signature __________________________ Date ________________
Asthma Treatment Plan – Student

(Please Print)

Name
Date of Birth
Effective Date
Doctor
Parent/Guardian (if applicable)
Emergency Contact
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.

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advair™ HFA 45, 60, 230</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Albuterol™</td>
<td>1 puff twice a day</td>
</tr>
<tr>
<td>Alvesco™ 80, 180</td>
<td>1 puff twice a day</td>
</tr>
<tr>
<td>Duolin™ 100, 200</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Flovent™ 44, 110, 220</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Ovar™ 40, 80</td>
<td>1 puff twice a day</td>
</tr>
<tr>
<td>Symbicort™ 80, 160</td>
<td>1 puff twice a day</td>
</tr>
<tr>
<td>Advair Diskus™ 100, 125, 160</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Asmanex™ Twinhaler™ 110, 220</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Flovent Diskus™ 50, 100, 250</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Pulmicort Flexhaler™ 190, 110</td>
<td>1 puff twice a day</td>
</tr>
<tr>
<td>Primatene Mist® (0.25%, 0.5%, 1%)</td>
<td>1 puff every 4 hours</td>
</tr>
<tr>
<td>Singulair™ (Montelukast)</td>
<td>1 tablet daily</td>
</tr>
</tbody>
</table>

If exercise triggers your asthma, take ______ puff(s) ______ minutes before exercise.

Remember to rinse your mouth after taking inhaled medicine.

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).

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuterol MDI (Pro-vent or Ventolin™)</td>
<td>2 puffs every 4 hours as needed</td>
</tr>
<tr>
<td>Xopenex™</td>
<td>1 puff every 4 hours as needed</td>
</tr>
<tr>
<td>Albuterol 1.25, 2.5 mg</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Duonab™</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Xopenex™ (levosalbut) 0.31, 0.63, 1.25 mg</td>
<td>1 unit nebulized every 4 hours</td>
</tr>
<tr>
<td>Combidril Respimat™</td>
<td>1 inhalation 4 times a day</td>
</tr>
<tr>
<td>Increase the dose of, or add:</td>
<td></td>
</tr>
<tr>
<td>Other: ________</td>
<td></td>
</tr>
</tbody>
</table>

• 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
• Noise opens wide - Rib's show
• Trouble walking and talking
• Lips blue - Fingernails blue
• Other: ________

And/or Peak flow below ________

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

<table>
<thead>
<tr>
<th>MEDICINE</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Albuterol MDI (Pro-vent or Ventolin™)</td>
<td>4 puffs every 20 minutes</td>
</tr>
<tr>
<td>Xopenex™</td>
<td>4 puffs every 20 minutes</td>
</tr>
<tr>
<td>Albuterol 1.25, 2.5 mg</td>
<td>1 unit nebulized every 20 minutes</td>
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<tr>
<td>Combidril Respimat™</td>
<td>1 inhalation 4 times a day</td>
</tr>
</tbody>
</table>

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

Permission to Self-administer Medication:
☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.
☐ This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE
Physician's Orders
PARENT/GUARDIAN SIGNATURE
PHYSICIAN STAMP

DATE

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

1. 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

2. 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

3. 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

4. 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.

[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.

[Signature]
[Phone]
[Date]
FARE
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: ___________________________ D.O.B.: ___________________________

Allergy to: ___________________________

Weight: __________ lbs. Asthma: [ ] Yes (higher risk for a severe reaction) [ ] No

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

Extremely reactive to the following foods:

THEREFORE:
[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.
[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR ANY OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/swallowing

MOUTH
Significant swelling of the tongue and/or lips

OR A COMBINATION
of symptoms from different body areas

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 them the child is having anaphylaxis and may need epinephrine when they 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 them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/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: ___________________________

Epinephrine Dose: 1 0.15 mg IM 1 0.3 mg IM

Antihistamine Brand or Generic: ___________________________

Antihistamine Dose: ___________________________

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

PARENT/GUARDIAN AUTHORIZATION SIGNATURE: ___________________________ DATE: ___________________________

PHYSICIAN/CP AUTHORIZATION SIGNATURE: ___________________________ DATE: ___________________________
EPiPen® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS
1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid Outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.

AUvi-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS
1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid Outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.

ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS
1. Remove the outer case.
2. Remove grey caps labeled “1” and “2”.
3. Place red rounded tip against mid Outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.

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 get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: __________________________ PHONE: __________________________
DOCTOR: __________________________ PHONE: __________________________
PARENT/GUARDIAN: __________________________ PHONE: __________________________

PARENT/GUARDIAN AUTHORIZATION SIGNATURE ________________________________________ DATE __________________________

OTHER EMERGENCY CONTACTS

NAME RELATIONSHIP: __________________________ PHONE: __________________________
NAME RELATIONSHIP: __________________________ PHONE: __________________________
NAME RELATIONSHIP: __________________________ PHONE: __________________________