Dear CDC Family,

The Heights Child Development Center uses Tuition Express to process tuition and fee payments safely, quickly and efficiently. All CDC families will be required to sign up for automated payments through Tuition Express. We will no longer accept cash or check for tuition payments. Tuition Express is a PCI Level 1 Service Provider, therefore your personal account information could not be safer.

We offer the following Tuition Express payment options:

- Automated Credit Card Transactions (VISA/MC only)
- Automated ACH Transactions

We are asking all families to complete the Tuition Express Parent Authorization Form and return it to us by August 1st. Once we have your completed form, your account information will be entered into our system and you will be set up for automated credit card or ACH transactions. This will allow us to collect payments from your credit card or bank account on the 1st of each month (or closest business day thereafter). Late fees will be assessed to any account that has not been updated or reconciled by the 10th of the month due to a decline in processing payments.

Please review the Tuition Express FAQ. There you will find answers to questions you may have regarding Tuition Express or automated payments in general. You may return your Tuition Express Parent Authorization Form by email to (theheightscdc@theheights.org), mail to The Heights Child Development Center, 201 W. Renner Rd, Richardson, TX 75080, or our Heights CDC Dropbox outside the Family Entrance doors. If you have further questions, please don't hesitate to ask.

Sincerely,

Holly Lieou

Financial Assistant
hlieou@theheights.org

Convenient and Safe
On-time Payments

PARENT FAQS

We are excited to offer automatic payments through Tuition Express. It is no longer necessary for you to write a check for tuition and fees. Your bank or credit card account will be safely and securely debited by Tuition Express. You can be emailed a receipt for each transaction. It's easy to sign-up – just ask us.

Frequently Asked Questions

When I pay my tuition automatically, how secure is my account information?
Very secure – more secure than when you write checks. The checks you write every day have your name, address, phone number, and sometimes your driver's license number on them. With this information, criminals have all they need to access your account or worse, steal your identity. Automatic payments greatly reduce this potential problem by limiting the amount of information available and who has access to it. Tuition Express also incorporates additional security procedures, utilizing 128 bit encryption.

What if the childcare center makes a mistake and takes out too much money?
Report the error to your childcare center immediately – it was most likely an honest mistake. The childcare center will then adjust your account accordingly.

What if my childcare center and I disagree about a payment?
If you feel that the payment should not have been made, you have the right to dispute the charge. Contact your bank or credit card company. Tuition Express and your childcare provider will work closely to resolve the issue in a timely manner.

Does this form of payment give the childcare center access to my account?
Nobody at the childcare center has access to your account. When you sign up for Tuition Express, you only authorize your bank or credit card company to release the exact amount owed to your provider when it is due and payable.

How will I know when a payment was taken out of my account?
Your childcare expenses will be taken out of your account on a schedule that you and the childcare center agree upon. Your childcare center has the ability to print statements for your records prior to the withdrawal of any money. Additionally, the charges will show up on your monthly statement as "Tuition Express".

When I sign up for Tuition Express, how will this help my childcare provider?
Your childcare provider has chosen to offer Automatic Payments for several reasons. First, it will give you the convenience of not having to write a check every time tuition and fees are due. Second, it allows regular scheduling of your payments. Most importantly, Automatic Payments reduce the amount of time your childcare center spends on management activities, giving staff more time to spend with the children.

How do I get started?
Simply complete the "Payment Authorization" form and return it to your childcare provider. They will do the rest! For more information on automatic payments, visit www.directpayment.org. This is an excellent resource explaining the system and its benefits.

Where can I learn more?
For more information on the benefits of Tuition Express, please visit us at www.tuitionexpress.com.

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Automated Payment Processing

Safe. Convenient. Easy.

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize (business name) The Heights Child Development Center to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name ______ Phone # ______

Cardholder Address ______ City ______ State ______ Zip ______

Account Number ______ Expiration Date ______ CVV ______

Cardholder Signature ______ Date ______

SECTION B (Bank Account)

Your Name ______ Phone # ______

Address ______ City ______ State ______ Zip ______

Bank or Credit Union Name ______ Bank or Credit Union Address ______ City ______ State ______ Zip ______

Routing Transit Number (see sample below) ______ Account Number (see sample below) ______ ☐ Checking ☐ Savings

Authorized Signature ______ Date ______

Your Name
Any Street, Anytown
Tel: (001) 555-0000

0001

DATE ______

PAY TO THE ORDER OF **ATTACH VOIDED CHECK HERE** $

DEPOSIT SLIPS NOT ACCEPTED /100 DOLLARS Security features included. Details on back.

BANK
Savings Bank
Any Street, Anytown
Tel: (001) 555-5555

RE ______ MP

123456789 000123456789 0001

ROUTING NUMBER | ACCOUNT NUMBER | CHECK NUMBER

FOR OFFICIAL USE ONLY

Date Received ______

Employee Signature ______

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THE HEIGHTS CHILD DEVELOPMENT CENTER

PERMISSIONS AND AGREEMENTS FORM

CHILD'S NAME: ____ DATE OF BIRTH: ________________

PLEASE INITIAL EACH SECTION

Parent Handbook (which includes our discipline and guidance policy):

_____I acknowledge that I will read The Heights Child Development Center Parent Handbook prior to my child's first day of school and will adhere to its guidelines. (Located online at www.theheightscdc.com under Parent Resources)

Photo/Video Permission and Release

I DO ____ DO NOT ____ give consent for photo/video of my child to be used within the building of The Heights Child Development Center. This will include in print or digital format in the classroom, hallways or to go home with enrolled families for memory purposes. *We do NOT publish photographs of individual children on our website or Facebook page.* In the case where marketing material is needed, we will contact persons on an as-needed basis in order to use photographs on material published for the general public.

Class Directory Permission

I DO ___ DO NOT ____ give consent for my child to be included in The Heights Child Development Center class directory. The following information will be included in the directory: child's name, parents' name, mailing address, phone number, email address.

Directories are only printed by request of a parent and only per each classroom. We never publish a whole-school directory, nor do we provide any information regarding your child to any third-party sources.

Tuition/Fee Agreement

_____I acknowledge that tuition and other fees are collected monthly through Tuition Express on the 1st of each month. I agree to keep my financial accounts updated to prevent payment declines, and I understand I will be assessed any fees incurred as a result of a decline.

Parent's Signature ____ Date _____________________

Printed Name of Parent ______________________________________

2023-2024 FAMILY INFORMATION SHEET

The information obtained on this sheet is for the purpose of the teachers in your child's class to better understand your child's family and culture environment, as well as personality and tendencies at home. This information can be very helpful in early childhood education in helping to better understand your child's development and well-being as an individual. All information is maintained in the classroom under confidentiality. Please answer as thoroughly as possible for your child.

Name of Child: ____ DOB: ______________________________

ALLERGIES: ____

Does your child have any of the following: (if yes, please explain)

Does your child have an EPI pen? Y N
Dietary restrictions? _____________________

Previous serious illness or injuries? ____________________
Hospitalization during the last 12 months? ______________
Any medication prescribed for long term use? ___________

How did you find out about The Heights CDC? ____

Previous preschool/MDO attendance? ( ) YES ( ) NO If yes, where: ___________________________________

Please Tell Us About Your Child's Family Environment:

Mom's Name: ____ Phone: _______________________________

Employer: ____ Occupation: __________________________

Dad's Name: ____ Phone: _______________________________

Employer: ____ Occupation: __________________________

Siblings (name and age): ____

Pets (type and name): ____

Are parents: ( ) Living together ( ) Separated ( ) Divorced Other: _________________________________

If separated or divorced, who has custody of the child? ____

Are there any other adults living in the home? ____

(form continued on back)

Please Tell Us About Your Child's Culture:

Ethnicity: White African-American Hispanic Indian Asian Pacific Islander

Other: ____

What is the primary language spoken at home? ____

What holidays or special traditions do you and your family celebrate? __________________________________

Church attending: ____ No church home: [ ] (please check here)

Anything else you would like us to know about your child's culture?

____

____

____

Please Tell Us About Your Child's Individual Personality and Behavior/Medical Concerns:

Describe your child's personality: ____

Child's fears or habits we need to be aware of: ____

Describe your child's sleeping habits at naptime, and any information that the teacher could use to assist them in falling asleep: ____

____

Are there any other issues regarding your child's health and/or behavior of which we should be aware?

____

Is your child potty trained: ( ) Yes ( ) No Please list any special words used to go to the restroom:

____

Do you feel there can be a language barrier with the potty training process?

____

Please list any other special concerns, medical needs, or any additional information that will help us make your child's school year the best it can be:

____

____

____

____

THE HEIGHTS CHILD DEVELOPMENT CENTER

EMERGENCY MEDICAL INFORMATION AND AUTHORIZATIONS

CHILD'S NAME ___________________________ ________________________ __________________ ___________________________

(Last) (First) (Middle) (Name Called)

DATE OF BIRTH_________________________________ **ALLERGIES:**____

(Month/Day/Year) (Please complete allergy information sheet on back side of form)

PARENT / GUARDIAN NAME(S) ____

PARENT / GUARDIAN PHONE NUMBER(S) ____

PARENT / GUARDIAN EMAIL ADDRESS(ES) ____

EMERGENCY CONTACTS

Emergency Contacts are someone *other than the parent/guardian* that can be contacted in the case of an emergency that know medical information regarding the child. These persons do not have to be local.

(*Minimum of 2 contacts with address and phone number required)*

Emergency Contact #1 (OTHER THAN PARENT OR GUARDIAN)

Name: ____ Relationship to child: _____________________

Address: ____

Phone: _________________________________

Emergency Contact #2 (OTHER THAN PARENT OR GUARDIAN)

Name: ____ Relationship to child: _____________________

Address: ____

Phone: _________________________________

**A child will only be released from The CDC to his/her mother, father, or other persons authorized by the parents. In the case of marital separation, THBC cannot deny either parent access to a child unless copies of legal documentation stating otherwise are provided.

AUTHORIZED PICK-UP PERSONS: (will not be contacted in emergency – this only gives permission to release your child to this person without having to contact the parent/guardian first – must present PHOTO ID)

NAME: _________________________________ RELATIONSHIP: ____________________ PHONE #: ____________________________

NAME: _________________________________ RELATIONSHIP: ____________________ PHONE #: ____________________________

NAME: _________________________________ RELATIONSHIP: ____________________ PHONE #: ____________________________

Authorization for Emergency Medical Attention:

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to contact the Physician below:

Name of Physician: ____________________ Address: ___________________________________ Phone: _______________________

And/or the closest emergency medical facility as determined by first responders in the case of a 911 call:

Methodist Richardson Medical Center, 2831 E President George Bush Highway, Richardson, Texas 75080 PH: 469-204-1000

I give consent for the facility to secure any and all necessary emergency medical care for my child.

Parent's Signature: ____ **Date:** ___________________________

THE HEIGHTS CDC RESERVES THE RIGHT TO CALL 911 IN ANY EMERGENCY SITUATION

THE HEIGHTS CHILD DEVELOPMENT CENTER

ALLERGY PLAN FOR DIAGNOSED ALLERGIES

CHILD'S NAME _________________________ _______________________ _________________ _________________________
(Last) (First) (Middle) (Name Called)

DATE OF BIRTH_______________________________ **ALLERGIES:**____
(Month/Day/Year)

Please complete the following form for all MEDICALLY DIAGNOSED allergies.

Allergen: ____

Is the allergy to touch or ingestion: ____

Symptoms *(please describe any known symptoms to the allergen):*

____

____

Does your child have an EPI pen? ______ YES ______ NO

_____ If checked, give Epinephrine immediately for any LIKELY ingestion, for ANY symptoms.

_____ If checked, give Epinephrine immediately for any DEFINITE ingestion, even with no symptoms

---

Allergen: ____

Is the allergy to touch or ingestion: ____

Symptoms *(please describe any known symptoms to the allergen):*

____

____

Does your child have an EPI pen? ______ YES ______NO

_____ If checked, give Epinephrine immediately for any LIKELY ingestion, for ANY symptoms.

_____ If checked, give Epinephrine immediately for any DEFINITE ingestion, even with no symptoms

---

____ _________________________
PARENT/GUARDIAN SIGNATURE **DATE**

____ _________________________
PHYSICIAN SIGNATURE **DATE**

THE HEIGHTS CHILD DEVELOPMENT CENTER

HEALTH ADMISSION REQUIREMENTS

Child's Name: _______________________________ Date of Birth: ___________ Today's Date: ______________

IMMUNIZATION REQUIREMENT: (Check One)

[ ] Attached is a copy of the Immunization Records for the child listed above. I understand that it is my responsibility to bring updated records to the office throughout the year as immunizations are administered.

[ ] I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for two years.

STATEMENT OF HEALTH REQUIREMENT

One of the following must be presented when your child is admitted to the CDC program or within one week of admission.

1. [ ] A PHYSCIAN'S STATEMENT *with signature* is attached.
2. [ ] AFFIDAVIT: stating that medical diagnosis and treatment conflict with the tenants and practices of a recognized religious organization which I adhere to or am a member of; *I have attached a signed and dated affidavit stating this.* Parent's Initials: ___________
3. [ ] PHYSCIANS STATEMENT: I have examined the above named child within the past year and find that he/she is physically able to take part in the preschool program. ****PHYSICIAN SIGNATURE REQUIRED**

______________________________ ____________________

PHYSICIAN SIGNATURE DATE

____

Please Print: Physician Name/Physician Address/ Physician Phone Number

HEARING AND VISION REQUIREMENT

4 & 5 YEAR OLDS ONLY AS OF SEPTEMBER 1ST

(Please check only one option)

[ ] I have attached a copy of the hearing and vision screening results for the above named child.
[ ] Results for the hearing and vision screening are as follows:

VISION: **R** 20/__________ **L** 20/__________ [ ] **PASS** [ ] **FAIL**

HEARING: **1000HZ** **2000HZ** **4000HZ**

R: _______________/ ______________/ ________________ [ ] **PASS** [ ] **FAIL**

L: _______________/ ______________/ ________________

______________________________ ____________________

PHYSICIAN SIGNATURE DATE

Form 2550
October 2019-E

Operational Policy on Infant Safe Sleep

This form provides the required information per minimum standards §746.501(9) and §747.501(6) for the safe sleep policy.

Directions: Parents will review this policy upon enrolling their infant at ______________________________
and a copy of the policy is provided in the parent handbook. Parents can review information on safe sleep and reducing the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death (SIDS/SUIDS) at: http://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx

Safe Sleep Policy

All staff, substitute staff, and volunteers at ______________________________ will follow these safe sleep recommendations of the American Academy of Pediatrics (AAP) and the Consumer Product Safety Commission (CPSC) for infants to reduce the risk of Sudden Infant Death Syndrome/Sudden Unexpected Infant Death Syndrome (SIDS/SUIDS):

- Always put infants to sleep on their backs unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional [§746.2427 and §747.2327].
- Place infants on a firm mattress, with a tight fitting sheet, in a crib that meets the CPSC federal requirements for full-size cribs and for non-full size cribs [§746.2409 and §747.2309].
- For infants who are younger than 12 months of age, cribs should be bare except for a tight fitting sheet and a mattress cover or protector. Items that should not be placed in a crib include: soft or loose bedding, such as blankets, quilts, or comforters; pillows; stuffed toys/animals; soft objects; bumper pads; liners; or sleep positioning devices [§746.2415(b) and §747.2315(b)]. Also, infants must not have their heads, faces, or cribs covered at any time by items such as blankets, linens, or clothing [§746.2429 and §747.2329].
- Do not use sleep positioning devices, such as wedges or infant positioners. The AAP has found no evidence that these devices are safe. Their use may increase the risk of suffocation [§746.2415(b) and §747.2315(b)].
- Ensure that sleeping areas are ventilated and at a temperature that is comfortable for a lightly clothed adult [§746.3407(10) and §747.3203(10)].
- If an infant needs extra warmth, use sleep clothing ______________________________ (insert type of sleep clothing that will be used, such as sleepers or footed pajamas) as an alternative to blankets [§746.2415(b) and §747.2315(b)].
- Place only one infant in a crib to sleep [§746.2405 and §747.2305].
- Infants may use a pacifier during sleep. But the pacifier must not be attached to a stuffed animal [§746.2415(b) and §747.2315(b)] or the infant's clothing by a string, cord, or other attaching mechanism that might be a suffocation or strangulation risk [§746.2401(6) and §747.2315(b)].
- If the infant falls asleep in a restrictive device other than a crib (such as a bouncy chair or swing, or arrives to care asleep in a car seat), move the infant to a crib immediately, unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health-care professional [§746.2426 and §747.2326].
- Our child care program is smoke-free. Smoking is not allowed in Texas child care operations (this includes e-cigarettes and any type of vaporizers) [§746.3703(d) and §747.3503(d)].
- Actively observe sleeping infants by sight and sound [§746.2403 and §747.2303].
- If an infant is able to roll back and forth from front to back, place the infant on the infant's back for sleep and allow the infant to assume a preferred sleep position [§746.2427 and §747.2327].
- Awake infants will have supervised “tummy time” several times daily. This will help them strengthen their muscles and develop normally [§746.2427 and §747.2327].
- Do not swaddle an infant for sleep or rest unless you provide Form 3019, Infant Sleep Exception/Health Care Professional Recommendation, signed by the infant's health care professional [§746.2428 and §747.2328].

Privacy Statement

HHSC values your privacy. For more information, read our privacy policy online at: https://hhs.texas.gov/policies-practices-privacy#security.

Signatures

This policy is effective on: ________________ Child's name: ______________________________

Signature — Director/Owner	Date Signed
Signature — Staff member	Date Signed
Signature — Parent	Date Signed

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

PLACE PICTURE HERE

Name: ______________________ D.O.B.: __________

Allergic 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 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

OR A COMBINATION of symptoms from different body areas.

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): ______________

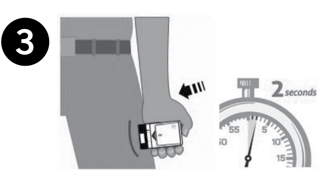
____

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

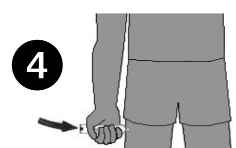
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

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: ____________

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