Stepping Stone Preschool

Excellence in Education since 1968

General Info

Potential Family Information Sheet

Mother's Name _____ Father's Name _____

Address _____ Address _____

City _____ State Zip _____ City _____ State Zip _____

(___) _____ Home (___) _____ Work (___) _____ Home (___) _____ Work

(___) _____ Cell _____ Email address (___) _____ Cell _____ Email Address

_____ _____ M_____ F_____ Is Child living with both Parents? Yes No
Child's Name DOB If no, who _____

_____ _____ M_____ F_____ Is Child living with both Parents? Yes No
Child's Name DOB If no, who _____

_____ _____ M_____ F_____ Is Child living with both Parents? Yes No
Child's Name DOB If no, who _____

Placement Info:

Desired Date of Entry: _____/Fall/Summer/Spring Is child potty trained? Yes No Working on it NA

I am interested in: ____ Full Time (M-F) ____ Summer Care

Preschool: ___6wks-11mos___12mos-17mos___18mos-23mos___2's___3's___4's___PreK

Afterschool Pickup and Care until 6:30pm: __Owens, __Jack, __Rice, __Andy Woods, __Cumberland, __TCA, __Stanton Smith, __Cain, __Brown, and __Higgins **Summer Care Only**___PreK___1-5th

Does your child have any special needs/circumstances you feel we need to know to determine placement?

_____

_____.

Other Information:

Previous School _____ How Long?_____

Reason for Leaving? _____.

I am interested in Stepping Stone because....

_____

_____.

How did you hear about Stepping Stone?

Referred by _____Advertising: Radio ____ TV____

Phone Book ____ Internet _____Other _____

I understand that **ALL** fees paid are **non-refundable** and that if I am offered a space to begin for the semester I designated, but choose not to take that space, I must pay the fees again to remain on the list. In the event that space is not available, you will remain on the list.

Signature _____ Date _____

Office Use Only:

Entered By _____ Paid ck # _____ Credit Card Cash Amount Paid _____

5113 Timber Creek Dr. • Tyler, TX 75703
903-566-1851 • FAX 903-566-0655
www.steppingstonetyler.com

Enrollment Application

(Please complete one per child)

About my child:

Child's Name (Last, First, Middle Initial)			Nickname:
Date of Birth	☐Female☐Male	Date of Enrollment:	With Whom Does the Child Live? ☐ Mother☐ Father☐ Both☐ Guardian (Specify)
Home Address:		Home Phone:	Alt Phone:
Expected hours/days of attendance:			

Primary Contact Persons:

Parent/Guardian 1		Relationship to child:
Home Address:		Home/Cell:
Employer	Employers Address:	Work Phone:
Occupation:	Driver's License #/State	Email Address:
Parent/Guardian 2		Relationship to child:
Home Address:		Home/Cell:
Employer	Employers Address:	Work Phone:
Occupation:	Driver's License #/State	Email Address:

Required by Texas Department of Family and Protective Services (DFPS): **At least one emergency contact that is authorized to pick up your child** in the event that neither parent/guardian can be reached. Your child will not be release to anyone who is not listed on this page without **YOUR** written permission. "I hereby authorize Stepping Stone School to allow my child to leave with the following people:"

Name:		Relationship to child:
Home Address:	Phone:	Alt Phone:
Name:		Relationship to child:
Home Address:	Phone:	Alt Phone:

I authorize my child to be released to the care of his/her sibling(s) under the age of 18 years old.

Name of Sibling: _____

Emergency Information:

In case of illness or injury, first please contact: □Mother □Father □other (please specify: _____)

Name	Relationship to child	Address	Phone Number

"In the event I cannot be reached to make arrangements for emergency medical care at the time of illness or accident, I hereby authorize an employee of Stepping Stone School to take my child to the following physician/hospital/clinic, and I give my consent for necessary emergency care when my child is in the care of this physician/hospital/clinic"

Name of Physician:	Address:	Phone Number:	
□Trinity Mother Frances 800 Dawson, Tyler TX 75701 903-593-8441	□ETMC 1000 S. Beckham, Tyler, TX 75701 903-597-0351	□UTHCT 11937 US Hwy 271, Tyler, TX 75708 903-877-7777	□Other: _____ Address: _____ Phone: _____

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

Child Information and Health History:
Please list any allergies, existing illnesses, previous illnesses/hospitalizations during the past 12 months. Also list any medications that your child is taking long term.
Allergies:

_____

Illnesses:

_____

Hospitalizations:

_____

Long term medications:

_____

Pre-Kindergarten Children: Children who are 4 years of age by September 1st are required by The Special Senses and Communication Disorders Act to undergo a professional screening for vision and hearing problems annually. Stepping Stone School offers this professional screening on-site each year for an additional fee. Documentation of these screenings must be in the child's file and updated annually until he/she starts elementary school.
Parent/Guardian Signature: _____ **Date** _____

Permissions:	**Parents Initials**
I hereby □give □do not give my consent for my child to ride a bus.	
I hereby □give □do not give my consent for my child to be transported and supervised by the operations employees for □emergency care □field trips	
I hereby □give □do not give my consent for my child to participate in water activities (water table/sprinkler play/splashing or wading pools/swimming pools).	
I hereby □give □do not give my consent for Stepping Stone to apply bug repellant as necessary.	
I hereby □give □do not give my consent for Stepping Stone to apply sunscreen as necessary.	
I hereby □give □do not give my consent for Stepping Stone to apply diaper cream as necessary.	
I hereby □give □do not give my consent for Stepping Stone to administer □Tylenol □ibuprofen □Benadryl	
I hereby □give □ do not give my consent for my child's picture to be used for publicity purposes. (This may include face book, advertising, newspaper/news reports. This list in not meant to be all inclusive).	

General Release of Liability
Stepping Stone School, their agents and employees shall not be liable or responsible for and shall be held harmless by the undersigned from and against any and all claims and damages of every kind, including, but not limited to, injury or death of any person or persons and for damage to or loss of property arising out of or attributed directly or indirectly to the operations of the school or the performance of the school or its owner or employees in carrying out its child care and school functions and specifically including:

1.) Transportation to and from the school premises and while off premises for any school related activity. (A specific field trip permission form will be signed by parents for each field trip prior to any child leaving the school.)
2.) Swimming or other water activities on or off premises.
3.) Any other activity for which permission for the child's participation has been approved by a parent or guardian.

I have included a copy of my child's immunization record and physician's health statement. I understand that my child's file is incomplete until all required documentation is on file and enrollment will not be complete without it. I also understand that I must provide the center with an updated immunization record as available and an updated health statement annually. Stepping Stone must also be notified immediately any time the parent/guardian/emergency contact information has changed.

Parent/Guardian Signature _____ Date _____

Child History

Was the pregnancy full term? ☐ Yes ☐ No	Was your child adopted? ☐ Yes ☐ No
Were there any complications during pregnancy/delivery? ☐ Yes ☐ No If yes, please explain:	

Home and Family

Status of Parents: ☐ Married ☐ Divorced ☐ Separated ☐ Other: _____

Child lives with:

Name	Age	Relationship

If your child doesn't live with both parents, is there anything we should know about his/her experiences with either parent?

Child Care History

Has your child ever been separated from his/her primary caregiver for any length of time? ☐ Yes ☐ No Please explain:

Has your child ever been in a group setting before? ☐ Yes ☐ No Please Explain:

If yes, how did your child adjust to this environment?

Health

Is your child usually hungry for meals? ☐ Yes ☐ No Snacks? ☐ Yes ☐ No

Does your child have any food allergies? ☐ Yes ☐ No If yes, please list in detail below:

Favorite Foods:	Refused Foods:

Do you have any concerns about your child's eating habits? ☐ Yes ☐ No If yes, please explain:

Is your child on any type of special diet? ☐ Yes ☐ No If yes, Please explain:

What time does your child go to bed?	Wake Up?	Nap?

Do you have any concerns about your child's sleeping habits? ☐ Yes ☐ No If yes, please explain:

Does your child use the toilet? ☐ Yes ☐ No

Do you have any concerns about your child's use of the toilet? ☐ Yes ☐ No If yes, Please explain:

Does your child have any special needs?

Does your child have regular contact with children of his/her own age? ☐ Yes ☐ No

How does your child get along with other children?

General Information

What would you like us to know about your child?
What are your goals for your child while at Stepping Stone?
Please use this space to provide us with any additional information about your child?

Prior child care/school history

Has your child been enrolled at a previous child care/day care/in home center? Yes No If yes, where? _____ How Long? _____ Reason for leaving? _____
Has your child ever been dismissed from a previous center? Yes No If yes, please explain:
What did you like about your child's previous provider? _____ What did you dislike? _____ How did you hear about Stepping Stone? _____

Additional Items:

____My child will be on the hot lunch program. I understand that there is an additional $65.00 fee.

____ I will provide my child with a lunch each day. I understand that daily hot lunch orders are not accepted.

____ My child will need a mat cover for an additional fee of $12.00. Each child must have a mat cover each day, if I fail to bring a mat cover, one will be given to your child and your account will be charged accordingly.

____ Yes, I would like to purchase additional key tags (3 per family maximum) $10.00 each.

Key holder 1 _____

Key holder 2 _____

Key Holder 3 _____

Enrollment Agreement
Please read and initial EACH section listed below, and sign the last page.

Tuition & Fees

____Registration fee: I understand that a Registration fee is due for each child upon enrollment, then every August. Registration fees are non-refundable, nor are they pro-rated.

____Enrichment Fees: Enrichment fees are due each semester for which your child is enrolled. All enrichment fees are non-refundable, nor are they pro-rated.

____ Tuition payments are due on every Monday, on the 1st and the 15th or on the 1st of each month. Families are to submit their billing preference in writing. In the event that you need to change your billing cycle, you must do so in writing.

____ I understand that rates are subject to change with reasonable notice as conditions require.

____ Late fees will be billed at a rate of 10% of the balance or $10.00 (whichever is greater) as follows:
Weekly: for payments not received by the close of business on Tuesdays.
Semi-Monthly: for payments not received by the close of business on the 3rd and 18th.
Monthly: For payments not received by the close of business on the 3rd.
Late fees will continue to bill for ANY account balance after the close of business on Tuesdays at a rate of 10% if the balance or $10.00 (whichever is greater).

____Agency Reimbursement: I understand that I am solely responsible for full tuition and late fees in the event an agency or third party fails to pay.

____ Late Pick Up: Stepping Stone is open from 6:30am to 6:30pm, Monday thru Friday. I understand that I will be charged a late pick up fee of $25.00 PLUS $1.00 per minute any time a Stepping Stone employee is responsible for your child after 6:30pm.

____ Discounts: Stepping Stone offers a 7% sibling discount when one or more child is attending Stepping Stone School. The discount will apply towards the oldest child. Discounts are not applied for Prek or School Aged children during the summer. Discounts are not applicable on any fees or services, agency co-pays, or special program promotions.

____ Returned Checks: I understand that a $30 processing fee will be charged to my account for all checks that are returned for any reason.

Daily Procedures:

____ Daily sign in and sign out: I agree to sign my child in and out every day using the school's sign in and out procedure. I understand that I must escort my child to and from their class.

___ Illness: I understand that I will be notified should my child become ill during the day and that I will pick up my child promptly or make arrangements for and authorized contact to provide pick up. If my child is exposed to or contracts a contagious disease, I agree to notify the school and I understand that my child will be re-admitted according to the Illness Policy in the Parent Handbook.

___Interviewing Children and Inspecting Records: I understand that the state child care regulatory enforcement and administration agency and the local department of social services or child protective services has the authority to interview children or staff, to inspect and audit child or facility records, to interview children privately, to observe the physical condition of the children in the school, to make provisions for the independent medical examination by a licensed physician of any child, and to contact and instruct any other appropriate authority to do the same, without prior notice or consent by myself or by the school.

____Withdrawal from program: I understand that I must provide a 30 day notice of withdrawal from the program. I will be responsible for the full 30 days of tuition or fees regardless of my child's attendance.

Holidays, absences & closings:

___I understand that no credits will be issued for holidays, unexpected or scheduled school closings, absences or student vacations. Tuition is still due at the regular rate regardless of your child's attendance.

____**State Licensing & Policies**: I understand that the above policies are not an all-inclusive list of policies, and that my child, my family members, authorized agents and I are bound by state child care regulations, the Parent Handbook, and all other company policies, which may be modified at any time, without notice. I also understand that the child care regulations may prevail over these policies when the state regulation is stricter. I further understand that my continued enrollment constitutes my acknowledgement of, and agreement to abide by, all policies and state regulations.

____ **Parent Handbook**: I have received a copy of the Parent Handbook. I have read and understand its contents and policies.

____ **Documents & Records:** I understand and agree that all documents or records kept, provided to or maintained by Stepping Stone are the property of Stepping Stone. I understand that any requests for records will be charged $5.00 per occurrence. All requests must be made in writing; Stepping Stone will have at least 5 business days, to complete the request.

_____

Parent Signature Date

Payment Options:

____ Weekly due each Monday. Late fees will be applied to accounts that have a balance due after the close of business on Tuesdays.

____ Semi-Monthly: Due on the 1st & 15th of each month. Late fees will be applied to accounts that have a balance after the close of business on the 3rd and 18th of each month.

___ Monthly: Due on the 1st of each month. Late fees will be applied to accounts that have a balance due after the close of business on the 3rd of each month.

Please see the current Preschool Brochure for pricing and fees

Parent/Guardians Initials _____

Parent Orientation

- Tour of the facility
- Introduction to teaching staff
- Parent visit with the classroom teacher
- Overview of parent handbook
- Policy for arrival & late arrival
- Opportunity for an extended visit in the classroom by parent and child.
- An explanation of Texas Rising Star Quality Certification
- Encourage parents to inform the center/provider of any elements related to their CCS enrollment that the provider may be assistance.
- An overview of family support resources and activities in the community.
- Child development and developmental milestones provided.
- Parents are informed of the significance of consistent arrival times.
- Statement about limiting technology use on site to improve communication between staff, children and families.
- Statement reflecting the role and influence of families.

_____ _____

Parent/Guardian Signature Date

Financial Responsibility Form

Child's Name _____ DOB_____
Mother's Name _____Father's Name _____
Who is Responsible for the tuition? _____ Check here if NOT mother/father ___
Name _____ DOB _____ SS# _____
Address _____ City _____ State _____ Zip _____
Phone _____ Alt Phone _____
Work Location _____ WK Phone _____

I choose to pay my tuition: Monthly Bi-Monthly Weekly

*Voluntary withdrawal of the above-named child requires a 30-day business day written notice. Tuition is due regardless of the child's attendance.

*Families may be dismissed at any time due to non-payment of their account first.

*All payments will be applied towards the oldest balance on the account first.

*Late fees are applied at a rate of 10% of the balance after the due date & will continue to post each week on Wednesdays.

*Stepping Stone offers auto payment from checking account or credit card to avoid additional late fees.

*Families who have an inconsistent payment history may be required to enroll in auto payment to remain enrolled.

*Families with past due balances will be sent to an outside collection agency & any records will not be released until the account is brought to a current status.

*Families who need to obtain copies of their records will be required to pay an additional fee of $10.00 for each occurrence.

For the complete financial policy of Stepping Stone School, see the Parent Handbook.

My signature below confirms that I have read, understand and agree with all financial policies.

_____ _____
Parent Signature Date

Online Payments

As a customer of Stepping Stone School, I (we) wish to register at www.tuitionexpress.com for the purpose of making online payments using a credit card.

Cardholder Name _____ Phone _____

Address _____ City _____ State_____

Cardholder Signature _____ Date_____

Office Use:

Date received :_____ Received by: _____

Credit Card Authorization Form

I (we) hereby authorize Stepping Stone School to initiate recurring credit card charges to the below referenced credit card account. To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice.

Cardholder Name _____ Phone _____

Cardholder Address _____ City _____ St___ Zip _____

Account Number_____ Exp Date _____ Sec Code _____

Cardholder Signature_____ Date _____

Please charge my card:

Eff Date _____

_____ Weekly _____ Semi-Monthly _____Monthly

_____ Check here if you wish to receive registration information to register online at www.tuitionexpress.com

---

Office Use:

Date received: _____ Received by:_____

Preferred Payment Method!!!

Save $10.00 per month

Bank Account Authorization Form

I (we) hereby authorize Stepping Stone School to initiate recurring debit entries to the below referenced checking or savings account. To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice.

Accountholder Name _____ Phone _____

Address _____ City _____ St___ Zip _____

Bank Name _____ Address _____

City _____ State _____ Zip_____

Routing No_____ Account No_____

Credit union members: Please contact your Credit Union to verify account and routing numbers for automatic payments

Signature_____ Date _____

Please debit my account:

Eff Date _____

_____ Weekly _____ Semi-Monthly _____Monthly

_____ Check here if you wish to receive registration information to register online at www.tuitionexpress.com

Please attach a voided check!

Office Use:

Date received: _____ Received by:_____

Form J-800-2710
New February 2017

INFANT-SLEEP EXCEPTION
HEALTH-CARE PROFESSIONAL RECOMMENDATION

Purpose: When a health-care professional determines that it is medically necessary for an infant to sleep in an alternative position (other than sleeping on the infant's back), sleep in a restrictive device (such as a bouncer seat or swing), or needs to be swaddled to sleep, use this form to ensure that a licensed child-care center, licensed child-care home, or registered child-care home that cares for the infant meets the minimum standards required by Texas Human Resources Code §42.042(e)(8). The standards for these operations require the operation to:

- follow the directions of an infant's health-care professional to provide specialized medical assistance to the infant; and
- maintain, while active, this form and any other directions from the health-care professional that the parent provides to the operation [See §746.603(a)(10) or §747.603(a)(9)]. Keep the exception form in the infant's classroom, so that a caregiver may refer to the health-care professional's instructions.

Directions: This exception will not be effective until all sections and signatures are complete. Once completed the exception is acceptable for use by the child-care operation.

INFANT'S INFORMATION		
Infant's Name:	Infant's Date of Birth:	Infant's Age:
Parent/Guardian's Name:		
Address:		
Home Phone:	Work Phone:	
Fax:	Email:	

The infant's health-care professional must complete the following section.

HEALTH-CARE PROFESSIONAL INFORMATION	
Name of Infant's Health-Care Professional:	
Name of Practice:	
Address:	
Phone:	Fax:
Email:	

The Texas child care minimum standards (§§746.2426, 746.2427 and 746.2428 for child-care centers or §§747.2326, 747.2327 and 747.2328 for licensed or registered child-care homes) require child-care operations to place all infants on their backs to sleep in a crib and to ensure that infants do not sleep in restrictive devices and are not laid down to sleep swaddled. But based on the advice of the infant's health-care professional, when medically necessary the center may be authorized to use an alternative-sleep position, restrictive device, or swaddle for the infant due to medical reasons.

The above-named infant has the following medical condition that necessitates an alternative-sleep position, allow for sleep in a restrictive device, or requires swaddling for sleeping:

Pandemic Emergency Response

In the event of a large scale or health related emergency the center will implement the Pandemic Section of the Crisis Management Plan under the guidance and direction of the CDC, federal and local governments, and the Texas Department of Health and Human Services Section for Child Care Regulation.

Pandemic is defined as the following:

1. *A disease prevalent over a whole country or world*
2. *An outbreak of a pandemic disease*

To ensure the safety of children, families and staff of the center, we will monitor the situation and consider the guidance and suggestions from the authorities on the situation. Decisions made by the center will consider the safety of children, families and staff. Decisions may include:

- Closure of the center
    - Length of closure to be determined by center, CDC, federal and local governments, the Texas Department of Health and Human Section for Child Care Regulation
- Adjusted hours of service
- Daily health checks of children and staff
- Limited entry into the building
- Limited access to the property
- Limitations on what the children may bring into the center, such as
    - Blankets
    - Stuffed animals
    - Pillows

The center will communicate these plans through a variety of methods such as the program's parent reminder system, mass emails and Facebook.

FARE Food Allergy Research & Education — 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

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

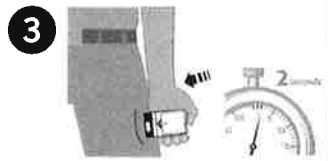
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

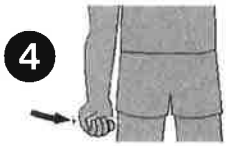
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



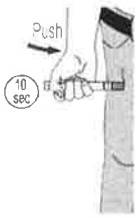
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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: _____

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