

The Harvest Sprouts Children's Day Out Program Emergency Form

Child'sName:_____ Preferred Name:_____

Age as of Sept. 1st:_____ Date of Birth:_____ Sex:____Religion and Church:_____

Address: _____ City/State/Zip Code: _____

Home Phone: _____ Email:_____

Mother'sName:_____ Cell #:_____ Email:_____

Father'sName:_____ Cell #:_____ Email:_____

Emergency Contact Information:

1.Name: _____Phone Number: _____ Relationship to child: _____

2.Name: _____Phone Number: _____ Relationship to child: _____

3.Name: _____Phone Number: _____ Relationship to child: _____

Authorized Persons to pick up (Other than Parents)

Name:_____Phone Number: _____ Relationship to child: _____

Name:_____Phone Number: _____ Relationship to child: _____

Name:_____Phone Number: _____ Relationship to child: _____

Name:_____Phone Number: _____ Relationship to child: _____

****Children will only be released to people listed above. ****

Medical Release Form and Health Information:

Medical Matters:

I hereby warrant to the best of my knowledge, my child is in good health and I assume all responsibility for the health of my child. Of the following statements pertaining to medical matters, sign only those in accordance with your wishes:

Emergency Medical Treatment:

In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor and I understand that all financial obligations are my responsibility.

In the event of an emergency and you are unable to reach me, I give permission for you to contact the emergency contacts or contact:

Child'sPrimary Care Physician: _____ Phone Number: _____

Address: _____ Preferred Hospital: _____

Medications:

My child will bring all such medications, well labeled, that are necessary. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency are as follows: My child is taking the following medication at the present time.

Medication(s): _____ Dosage: _____

Administer: _____

____I hereby **Do Not Grant Permission for** medication of any type, whether prescription or nonprescription my be administered by my child unless the situation is life threatening and emergency treatment is required. (Please Initial)

____ I hereby **Grant Permission** for nonprescription medication (such as Tylenol, throat lozenges, cough syrup) to be given to my child, if deemed advisable. I understand that Aspirin will not be given to my son/daughter. (Please Initial)

Medical Conditions Information: (Archdiocesan personnel will take reasonable care to see that the following information will be held in confidence.)

My son/daughter has:

- Has had an episode of the following or has been diagnosed: ___ Seizures ___ Asthma ___ Diabetic
- Allergic reactions to the following (foods, latex etc…)_____
- Has had a medical surgery within the last six months? ____ Yes ____ No
  Still under doctor's care? ___ Yes ___No
- Has a medically prescribed diet? _____
- The following physical limitations? _____
- Immunizations current and up to date? _____ (Must provide Current Immunization records)
- You should also be aware of these special medical conditions of my child (emotional, physical):_____

_ _____

Insurance Information: ___ No, I do not carry medical insurance at this time

Insurance Carrier: _____ Name of Insured:_____

Insurance Policy Number: _____

Father's Name: _____ Day Time Phone: _____

Mother's Name: _____ Day Time Phone: _____

In the Event it comes to the attention of the chaperones associated with the activity that my child becomes ill with

repeated symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called immediately. I fully understand the foregoing statements and sign this Parental/Guardian Medical Consent Waiver knowingly, freely, and willingly.

_____ _____ Signature

(Parent/Guardian) Date

Consent and Liability Waiver

I (name of parent/guardian) _____, grant permission for my child, _____ to participate in The Harvest Sprouts Children's Out Day to be held August 2026 through May 2027 at The Harvest Methodist Church .

In consideration of my child's participation in theThe Harvest Sprouts Children's Out Day Program, I agree on behalf of myself, my child named herein, and our heirs, successors, and assigns to indemnify, hold harmless and defend, the sponsoring church, its pastor, youth ministry leader, principal, other agents, employees or other representatives associated with the Children's Day Out Program from any and all injuries, losses or claims arising out of my child's participation in the event.

In signing this form I certify that all information contained herein is true and accurate to the best of my knowledge.

_____ _____ Signature

(Parent/Guardian) Date

Video/Photography Consent

As parent/guardian, I understand that promotional pictures and videos (individual and group) will be taken during The Harvest Sprouts Children's Out Day program. I give permission for my son's/daughter's picture to be used for promotional materials (newsletter, webpage, calendars, power point, video etc.) in highlighting the event.

_____ _____ Signature

(Parent/Guardian) Date

Walking Field Trip Permission Slip

Occasionally children enrolled inThe Harvest Sprouts Children's Out Day program, may leave the program room to experience learning in other areas of The Harvest Methodist Church. This may mean visiting the church to participate in children's worship and to use the playground. Children will never cross streets or leave The Harvest Sprouts Children's Out Day/ Methodist Church grounds during their time in the program.

My child_____ may participate in walking field trips within CDO.

My child_____ may not participate in walking field trips within CDO.

_____ _____ Signature

(Parent/Guardian) Date

Parent Handbook Acknowledgement:

I,_____ have received and read the The Harvest Sprouts Children's Out Day Parent Handbook. I agree to abide by the guidelines discussed in the handbook while my child is enrolled at The Harvest Sprouts Children's Out Day.

_____ _____ Signature

(Parent/Guardian) Date

Immunization Record and Physician's Statement

I authorize the release of this information in regard to the health of my child. Parent

Signature_____ Date_____

Child's Name	Date of Birth:

Vaccine	Date of 1st dose	Date of 2nd dose	Date of 3rd dose	Date of 4th dose	Date of 5th dose
Polio					
DTP/DtaP					
Hib					
Hepatitis B					
MMR					
Varicella					
Hep A					
PCV 7					

TB Test Date_____ Results_____

State Law requires for 4 year olds

Hearing Screening Date Results _____

Vision Screening Date Results_____

Immunization Record and Physician's Statement **PHYSICIAN'S STATEMENT**

_____ was examined and is able to participate in early (child's name) childhood program activities.

_____ ← _____

Physician's Signature (required) date

Physician's Name _____ Address_____

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:_____

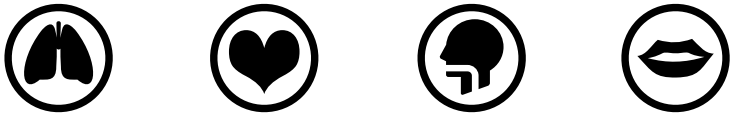
THEREFORE:

☐ 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

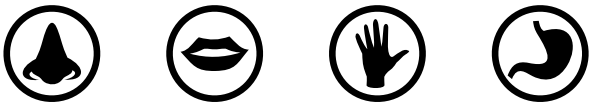
OTHER
Feeling something bad is about to happen, anxiety, confusion

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

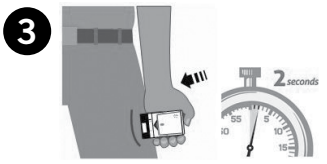
FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2020

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

FARE
Food Allergy Research & Education

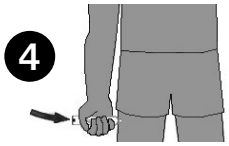
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

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.



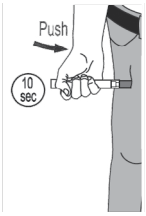
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

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

Parent Handbook Acknowledgement (2026/2027)

I,_____ have received and read the Parent Handbook for The Harvest Sprouts Children's Day Out Program. I agree to abide by the guidelines discussed in the handbook while my child is enrolled at The Harvest Sprouts.

Child's Name_____

Parent's Signature_____

Date_____