



Authorized Escorts List Form

The New York City Health Code requires child care centers to obtain and maintain, for every child, a list of all persons authorized by the parent/ guardian to escort the child from child care. The child care center shall not release any child to any individual who has not been identified by the parent/ guardian as a person who is authorized to escort a child out of the center.

Instructions: The parent/ guardian must complete, sign, and return this form to the child care center upon enrollment and update this form immediately when there is any change in authorized escort information.

I, _____, authorize this child care center to release my child, _____, to the individuals I have identified below.
(parent/ guardian name)
(child name)

Form for first authorized escort with fields for Name, Relationship to child, Home address, Preferred contact (checkboxes for Mobile/Cell Telephone, Home Telephone, Work Telephone, Text (Mobile), E-mail), Telephone (Mobile/Cell, Home, Work), and E-mail.

Form for second authorized escort with fields for Name, Relationship to child, Home address, Preferred contact (checkboxes for Mobile/Cell Telephone, Home Telephone, Work Telephone, Text (Mobile), E-mail), Telephone (Mobile/Cell, Home, Work), and E-mail.

Parent/ Guardian Signature: _____

Date: _____

In accordance with the requirements of the New York City Health Code, Article 47, Section 47.57(h)(1) child care centers must obtain and maintain for every child a list of the name, relationship to child, address and contact information of every person the parent has authorized to escort a child from the child care service. The permittee shall not release any child to any individual who has not been identified by the parent(s)/guardian(s) as a person who is authorized to escort a child out of the service.

HEALTH INFORMATION

Name of Physician/Clinic: _____ Telephone _____

Health Alert

Does child have any health condition that may affect participation in physical activities? Yes No

Limitations _____ (e.g., stair climbing, participation in gym)

Allergies _____

504 services for the current year? Yes No Previous Years? Yes No

My child has (X any that apply): Private health insurance Medicaid No health insurance

If "No Health Insurance," are you willing to share contact information from this card to learn about insurance options? Yes No

If none of the named contacts can be reached, what do you wish the school to do if your child is sick or injured?

It is understood that in the final disposition of an emergency case, the judgment of the school authorities will prevail.
The recommendation of the parent as indicated above will be respected as far as possible.

SIBLINGS

| Sibling's Last Name | Sibling's First Name | Sibling's School of Attendance |
|---------------------|----------------------|--------------------------------|
| | | |
| | | |
| | | |

SIGNATURE OF PARENT/GUARDIAN

Principal will be notified in writing of any changes to information on this card _____
Signature of Parent/Guardian

FOR SCHOOL USE ONLY

To be completed by school staff only.

Grade _____ Class _____ Room No. _____ Teacher _____

List below contacts made for emergency, illness or injury. Relevant records from Health Record _____

| Date | Contact | Reason | Disposition |
|------|---------|--------|-------------|
| | | | |
| | | | |
| | | | |

Allergy Response Plan

Student's Name: _____

DOB: _____

Teacher/Class: _____

School: _____

ALLERGY TO: _____

High risk for severe reaction (e.g. hx asthma): _____ Yes _____ No



General Signs of Severe Allergic Reaction:

Systems: Symptoms:

Mouth: Itching and swelling of lips, tongue or mouth

Throat*: Itching and/or a sense of tightness in throat, hoarseness, and hacking cough
Skin: hives, itchy rash, and/or swelling of face or extremities

Gut: Nausea, abdominal cramps, vomiting and/or diarrhea

Lung*: Shortness of breath, repetitive coughing and/or wheezing

Heart*: "Thready pulse", "passing out"

Note: the severity of symptoms can change quickly.

*These symptoms can potentially progress to a life-threatening situation.

If Exposure to Allergen is Suspected and/or Symptoms are:

1. Give (medicine/dose/route) _____ IMMEDIATELY!
2. Then call 911/EMS (ask for advanced life support) following school procedures for 911.
3. Call parent/guardian _____ or emergency contacts.
4. Call Dr. _____ at _____

DO NOT HESITATE TO CALL 911!

Trained School Staff

1. _____ Title _____ Room _____
2. _____ Title _____ Room _____
3. _____ Title _____ Room _____

Emergency Contacts (other than Parent/Guardian)

1. _____ Phone: _____
Relationship: _____
2. _____ Phone: _____
Relationship: _____

Nurse's signature: _____ Date: _____

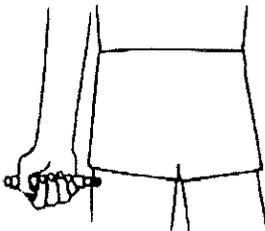
Parent/Guardian signature: _____ Date: _____

EPIPEN® AND EPIPEN® JR. DIRECTIONS

1. Pull off gray activation cap.



2. Hold black tip near outer thigh (always apply to thigh).



3. Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen® unit should then be removed and taken with you to the Emergency Room. Massage the injection area for 10 seconds.

(Adapted from the Food Allergy and Anaphylaxis Network)

Specific training on the Allergy Response Plan (including administration of epi-pen in an emergency if nurse is unavailable) to be given by school nurse to these school staff:
