Stamford Museum & Nature Center

Dear Parent(s),

You have noted your child has medications related to an allergic reaction. The Stamford Museum & Nature Center's requirements for noted medications are as follows:

Epi-pen requirements

- Need two epi-pens
- Epi-pens need to be in original box with prescription information from pharmacy
- Not expired
- Proper documentation and authorization form

Benadryl or other oral medications

- In original box
- Must include cup or spoon that indicates measured amount. Please write line on measurements with permanent marker that indicates amount doctor prescribed
- Proper documentation and authorization form

Other Medications (including inhalers)

- Medication in original container
- Labeled with child's name
- Proper documentation and authorization form

Please put above in a plastic Ziploc bag with your child's name on it .

Stamford Museum & Nature Center

To the parents of_____

You have registered a child for one of our programs and indicated that he or she has a documented "life threatening" food or insect allergy or other severe allegoric reaction that requires medication(s). In an emergency, we will follow the "protocol" within the parameters indicated on the following page, once approved by us, you, and your doctor.

Also, you must acknowledge that you understand the following by signing and dating this sheet:

1. **The Stamford Museum and Nature Center does not have a nurse.**
2. **Museum staff members are not allowed to drive anyone to medical facilities in an emergency. We will call 911 for transport to an ER.**
3. **Such foods common at our facility include birdseed, livestock feeds and all the wide variety of meal and snack foods that both the public on our grounds and other children in our programs eat. We cannot be responsible for accidental contact your child may have with these foods.**
4. **Stinging and biting insects are present within the museum environment and at some locations the full day camp takes field trips too.**
5. **You do understand and accept the risk involved as you place your child in our programs.**
6. **All instructors, aids and councilors on our staff can be privy to your child's allergy and potential reaction.**

_____ _____

Parents signature **Date**

We also require that the following sheets (enclosed) be filled out by you and your child's physician.

1. **"Allergy Protocol" sheet**
2. **"Authorization for the Administration of Medicines" sheet**

Stamford Museum & Nature Center

ALLERGY PROTOCOL for FOOD OR INSECT STING

ALLERGY To:_____

Child's Name_____

Child's Birthdate_____

Physician's name:_____

Address:_____

Telephone:_____

Please list protocols in appropriate sequence please:

_____Observe patient for severe symptoms

_____Administer EpiPen / EpiPen Jr. "before" symptoms occur

_____Administer EpiPen / EpiPen Jr. "if" symptoms occur

_____Administer PO Liquid Benadryl (dose)_____

_____Call 911 for transport to ER for observation

Preferred Hospital_____

_____ _____

Physician's Signature **Date**

_____ _____

Parent's Signature **Date**

EMERGENCY CONTACTS

1. Name_____ Relation _____ Contact Number_____

2. Name_____ Relation _____ Contact Number_____

3. Name_____ Relation _____ Contact Number_____

Oral Medications (i.e. Benadryl)

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel
In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth____/____/____ Today's Date____/____/____

Address of Child/Student _____Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? □YES □ NO

Condition for which drug is being administered: _____

Dosage _____Method /Route_____ Time of Administration _____ Start Date ____/____/____ End Date ____/____/____

Specific Instructions for Medication Administration _____

Dosage_____Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: _____/_____/_____ End Date: _____/_____/_____

Relevant Side Effects of Medication _____ □ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (_____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date _____/_____/_____

Parent/Guardian Authorization:

☐I request that medication be administered to my child/student as described and directed above

☐I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

☐I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____Town_____State_____

Home Phone # (_____) _____-_____ Work Phone # (_____) _____-_____ Cell Phone # (_____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: □YES □NO **Signature** _____ Date _____

Parent/Guardian authorization for self-administration: □YES □NO **Signature** _____ Date _____

Today's Date _____Printed Name of SM&NC Staff Receiving Written Authorization and Medication _____

Title/Position _____ **Signature (in ink)** _____

Note: This form in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

Epi-Pen

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel
In Connecticut schools, licensed Child Day Care Centers and Group Day Care Homes, licensed Family Day Care Homes, and licensed Youth Camps administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child shall provide the program with appropriate written authorization(s) and the medication before any medications are administered. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription.

Authorized Prescriber's (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth____/____/____ Today's Date____/____/____

Address of Child/Student _____Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? □YES □ NO

Condition for which drug is being administered: _____

Dosage _____Method /Route_____ Time of Administration _____ Start Date ____/____/____ End Date ____/____/____

Specific Instructions for Medication Administration _____

Dosage_____Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: _____/_____/_____ End Date: _____/_____/_____

Relevant Side Effects of Medication _____ □ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (_____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date _____/_____/_____

Parent/Guardian Authorization:

☐I request that medication be administered to my child/student as described and directed above

☐I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

☐I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____Town_____State_____

Home Phone # (_____) _____-_____ Work Phone # (_____) _____-_____ Cell Phone # (_____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: □YES □NO **Signature** _____ Date _____

Parent/Guardian authorization for self-administration: □YES □NO **Signature** _____ Date _____

Today's Date _____Printed Name of SM&NC Staff Receiving Written Authorization and Medication _____

Title/Position _____ **Signature (in ink)** _____

Note: This form in compliance with Section 10-212a, Section 19a-79-9a, 19a-87b-17 and 19-13-B27a(v.)

Other Medications (including inhalers)

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel
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Authorized Prescriber's (Physician, Dentist, Optometrist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child/Student _____ Date of Birth____/____/____ Today's Date____/____/____

Address of Child/Student _____Town_____

Medication Name/Generic Name of Drug_____ Controlled Drug? □YES □ NO

Condition for which drug is being administered: _____

Dosage _____Method /Route_____ Time of Administration _____ Start Date ____/____/____ End Date ____/____/____

Specific Instructions for Medication Administration _____

Dosage_____Method/Route_____

Time of Administration _____ If PRN, frequency_____

Medication shall be administered: Start Date: _____/_____/_____ End Date: _____/_____/_____

Relevant Side Effects of Medication _____ □ None Expected

Explain any allergies, reaction to/negative interaction with food or drugs_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____ Phone Number (_____) _____

Prescriber's Address _____ Town _____

Prescriber's Signature _____ Date _____/_____/_____

Parent/Guardian Authorization:

☐I request that medication be administered to my child/student as described and directed above

☐I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)

☐I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

Parent/Guardian Signature_____ Relationship_____ Date ____/____/____

Parent /Guardian's Address _____Town_____State_____

Home Phone # (_____) _____-_____ Work Phone # (_____) _____-_____ Cell Phone # (_____) _____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: □YES □NO **Signature** _____ Date _____

Parent/Guardian authorization for self-administration: □YES □NO **Signature** _____ Date _____

Today's Date _____Printed Name of SM&NC Staff Receiving Written Authorization and Medication _____

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