

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 .



threatening, emergency,	gistered a child for one of our programs and indicated that he or she has a documented "life" food or insect allergy or other severe allegoric reaction that requires medication(s). In an we will follow the "protocol" within the parameters indicated on the following page, once us, you, and your doctor.
Also, you mu	ust acknowledge that you understand the following by signing and dating this sheet:
1.	The Stamford Museum and Nature Center does not have a nurse.
	Museum staff members are not allowed to drive anyone to medical facilities in an emergency. We will call 911 for transport to an ER.
ı	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.
	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.
	All instructors, aids and councilors on our staff can be privy to your child's allergy and potential reaction.
Parents sign	

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

To the parents of ______



ALLERGY PROTOCOL for FOOD OR INSECT STING

ALLERGY To:				
Child's Name				
Child's Birthdate				
Physician's name:				
Address:				
Telephone:				
Please list protocols in ap	propriate sequence ple	ease:		
Observe patient for	severe symptoms			
Administer EpiPen /	EpiPen Jr. "before" sym	nptoms occur		
Administer EpiPen /	EpiPen Jr. "if" symptom	ns occur		
Administer PO Liqui	d Benadryl (dose)			
Call 911 for transpo	rt 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

Name of Child/Student _____ Date of Birth __/ __/ Today's Date __/ __/
Address of Child/Student _____ Town _____

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):

Medication Name/Deficite Name of Drug	Controlled Drug? □YES □ NO	
Condition for which drug is being administered:		
DosageMethod /Route Time of Administration	Start Date/ End Date//	
Specific Instructions for Medication Administration		-
DosageMethod/Route		
Time of Administration If PRN, fre	equency	
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	r drugs	
Plan of Management for Side Effects		
Prescriber's Name/Title	Phone Number ()	
Prescriber's Address	Town	
Prescriber's Signature	Date//	
Parent/Guardian Authorization:		
Parent/Guardian Authorization: □I request that medication be administered to my child/student a	s described and directed above	
□ I request that medication be administered to my child/student a □ I hereby request that the above ordered medication be adminis exchange of information between the prescriber and the school n	tered by school, child care and youth camp personnel and I surse, child care nurse or camp nurse necessary to ensure the	he safe administration of th
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Epi-Pen

Name of Child/Student ____

Authorization for the Administration of Medication by School, Child Care, and Youth Camp Personnel

Address of Child/Student ______Town_____

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.

_____ Date of Birth ___/ ___ Today's Date ___/ ___/

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

Medication Name/Generic Name of Drug	Controlled Drug? □YES □ NO	
Condition for which drug is being administered:		
DosageMethod /Route Time of Administration		
Specific Instructions for Medication Administration		
DosageMethod/Route		
Time of Administration If PRN, fre		
Medication shall be administered: Start Date://		
Relevant Side Effects of Medication		
Explain any allergies, reaction to/negative interaction with food or		
Plan of Management for Side Effects		
Prescriber's Name/Title		
Prescriber's Address		
Prescriber's Signature	Date/	
Parent/Guardian Authorization:		
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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 E	Birth// Today's Dat	e/	
Address of Child/Student	Town		
Medication Name/Generic Name of Drug	Controlled Drug?	P =YES = NO	
Condition for which drug is being administered:			
DosageMethod /Route Time of Administration Star	t Date/ End Date _	/	
Specific Instructions for Medication Administration			
DosageMethod/Route			
Time of Administration If PRN, frequency_		_	
Medication shall be administered: Start Date:/ End Dat	e:/		
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	_//	
□ I request that medication be administered to my child/student as describe □ I hereby request that the above ordered medication be administered by s exchange of information between the prescriber and the school nurse, child medication. I understand that I must supply the school with no more than a □ I have administered at least one dose of the medication to my child/stude Parent/Guardian Signature □	school, child care and youth camp d care nurse or camp nurse neces three (3) month supply of medicat ent without adverse effects. (For ch	sary to ensure the safe administration of tion (school only.) hild care only) Date/	
Parent /Guardian's Address			
Home Phone # () Work Phone # () SELF ADMINISTRATION OF MEDI			
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Self-administration of medication may be authorized by the prescriber and accordance with board policy. In a school, inhalers for asthma and cartridg medication with only the written authorization of an authorized prescriber a	e injectors for medically-diagnosed	d allergies, students may self-administe	r
Prescriber's authorization for self-administration: □YES □NO Sign	ature	Date	
Parent/Guardian authorization for self-administration: □YES □NO Sign	nature	Date	
Today's DatePrinted Name of SM&NC Staff Receiving Written	n 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.)