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 allergic 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.
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

Once received, SM&NC will create an individual care plan for your child that must be signed by parents, our camp director, and your child's camp educators. This is now required by Connecticut State Law. As a result, all forms must be submitted to SM&NC <u>ONE WEEK</u> before the start of your child's first camp session.

All forms must be on file with SM&NC ONE WEEK before the start of your child's first camp.

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.

All forms must be on file with SM&NC ONE WEEK before the start of your child's first camp.

Stamford Museum & Nature Center

ALLERGY PROTOCOL for FOOD OR INSECT STING

ALLERGY To: _____ Place Your Child's Photo Here

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 _____

All forms must be on file with SM&NC ONE WEEK before the start of your child's first camp.

Oral Medications

Authorization of the Administration of Medication

Authorized Prescriber's Order

Name of Child_____Date of Birth____/___/___Today's Date____/___/___

Address of Child: _____

Medication Name_____Controlled Drug? □ Yes □ No

Dosage_____Method_____Time of Administration_____

Medication Administration: Start Date___/___/___End Date____/___/___

Is this medication to be self-administered by the child? □ Yes □ No

Relevant side effects to be observed, if any _____

_____

Plan of Management for Side Effects _____

Prescriber's Name/Title _____Phone Number (____) _____

Prescriber's Address_____Town_____

Prescriber's Signature _____

AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION BY MUSEUM PERSONEL

To: The Stamford Museum and nature Center:

I hereby request that the above medication(s), ordered by the prescriber above for my child_____, be administered by museum personnel in an apparent life-threatening situation for which it was intended. If EpiPens-I understand that I must supply the museum with 2 (two) in the original container, dispensed and properly labeled by a physician or pharmacist. Benadryl (liquid form only) must also be in the original container, dispensed and properly labeled by a physician or pharmacist and include a calibrated medicine spoon. I will supply each in a clear plastic bag large enough to hold a folded protocol sheet with.
I understand that medications will be destroyed if not picked up within one week of the conclusion of my child's program.

Parent/Guardian Signature:_____Date_____

Address:_____Telephone (___) _____

All forms must be on file with SM&NC ONE WEEK before the start of your child's first camp.

Epi-Pen

Authorization of the Administration of Medication

Authorized Prescriber's Order

Name of Child_____Date of Birth____/___/___Today's Date____/___/____

Child's Address: _____

Medication Name_____Controlled Drug? □ Yes □ No

Dosage_____Method_____Time of Administration_____

Medication Administration: Start Date____/___/____End Date____/___/____

Is this medication to be self-administered by the child? □ Yes □ No

Relevant side effects to be observed, if any _____

_____

Plan of Management for Side Effects _____

Prescriber's Name/Title_____Phone Number (_____

Prescriber's Address_____Town_____

Prescriber's Signature _____

AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION BY MUSEUM PERSONEL

To: The Stamford Museum and nature Center:

I hereby request that the above medication(s), ordered by the prescriber above for my child_____, be administered by museum personnel in an apparent life-threatening situation for which it was intended. If EpiPens-I understand that I must supply the museum with 2 (two) in the original container, dispensed and properly labeled by a physician or pharmacist. Benadryl (liquid form only) must also be in the original container, dispensed and properly labeled by a physician or pharmacist and include a calibrated medicine spoon. I will supply each in a clear plastic bag large enough to hold a folded protocol sheet with.
I understand that medications will be destroyed if not picked up within one week of the conclusion of my child's program.

Parent/Guardian Signature:_____Date_____

Address:_____Telephone (___) _____

All forms must be on file with SM&NC ONE WEEK before the start of your child's first camp.

Other Medications (including inhalers)

Authorization of the Administration of Medication

Authorized Prescriber's Order

Name of Child_____Date of Birth____/___/___Today's Date____/___/___

Child's Address: _____

Medication Name_____Controlled Drug? □ Yes □ No

Dosage_____Method_____Time of Administration_____

Medication Administration: Start Date___/___/___End Date____/___/___

Is this medication to be self-administered by the child? □ Yes □ No

Relevant side effects to be observed, if any _____

_____

Plan of Management for Side Effects _____

Prescriber's Name/Title_____Phone Number (____)_____

Prescriber's Address_____Town_____

Prescriber's Signature _____

AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION BY MUSEUM PERSONEL

To: The Stamford Museum and nature Center:

I hereby request that the above medication(s), ordered by the prescriber above for my child_____, be administered by museum personnel in an apparent life-threatening situation for which it was intended. If EpiPens-I understand that I must supply the museum with 2 (two) in the original container, dispensed and properly labeled by a physician or pharmacist. Benadryl (liquid form only) must also be in the original container, dispensed and properly labeled by a physician or pharmacist and include a calibrated medicine spoon. I will supply each in a clear plastic bag large enough to hold a folded protocol sheet with.
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Parent/Guardian Signature:_____Date_____

Address:_____Telephone (___) _____

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