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.
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 allergenic 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
Asthma Action Plan  
Ages 0 – 11 Years

Name: 
Parent/Guardian Phone #s: Provider Phone #: Fax #: (or stamp)

Important! Things that make your asthma worse (Triggers): 
- smoke  
- pets  
- mold  
- dust  
- tree/grass/weed pollen  
- colds/viruses  
- exercise  
- seasons: other:

Severity Classification:  
- Severe Persistent  
- Moderate Persistent  
- Mild Persistent  
- Intermittent

GO – You’re Doing Well! 

You have all of these:  
- Breathing is good  
- No cough or wheeze  
- Sleep through the night  
- Can work and play

Peak Flow may be useful for some kids.

CAUTION – Slow Down!

You have any of these:  
- First signs of a cold  
- Exposure to known trigger  
- Cough  
- Wheeze  
- Tight chest  
- Coughing at night

Continue with Green Zone Medicine and Add:

RESCUE MEDICINE

DIRECTIONS

☐ If your child usually has symptoms with exercise then give:

☐ Inhalers work better with spacers. Always use with a mask when prescribed.

DANGER – Got Help!

Take these medicines and seek medical help now!

RESCUE MEDICINE

DIRECTIONS

☐ If rescue medication is needed more than 2 times a week, call your doctor at:

Make an appointment with your primary care provider within two days of an emergency visit, hospitalization, or anytime for ANY problem or question with asthma

School Nurse: Call provider for control concerns or if rescue medication is used more than 2 times/week for asthma symptoms

Parents: Call your doctor for control concerns if rescue medication is used more than 2 times/week for asthma symptoms

HEALTHCARE PROVIDER SCHOOL MEDICATION AUTHORIZATION REQUIRED for ____________________________ as stated in accordance with CT State Law and Regulations 10-212a

Self-Administration:☐ This student is capable to safely and properly self-administer this medication OR ☐ This student is not approved to self-administer this medication

Signature: ____________________________ Provider Printed Name: ____________________________ Date: ____________ For use from ____________ to ____________

Parent/Guardian Consent: REQUIRED
☐ I authorize this medication to be administered by school personnel OR ☐ I authorize the student to possess and self-administer medication.

I also authorize communication between the prescribing health care provider, the school nurse, the school medical advisor and school-based clinic providers necessary for asthma management and administration of this medication.

Parent/Guardian Signature: ____________________________ Date: ____________  

*Bring asthma meds and spacer to all visits
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 Order (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: ___________________________
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 ___/___/___

School Nurse Signature (If applicable) ___________________________

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 with the exception of emergency medications 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 ___/___/___
School nurse, if applicable, approval for self-administration: ☐ YES ☐ NO _______ Signature ___________________________ Date ___/___/___

Today’s Date ___________________________ Printed Name of Individual Receiving Written Authorization and Medication ___________________________
Title/Position ___________________________ Signature (in ink or electronic) ___________________________

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

Name of Child/Student _______________________________ Date of Birth _____ / _____ / _____

Pharmacy Name _______________________________ Prescription Number __________________

Medication Order _______________________________

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<th>Date</th>
<th>Time</th>
<th>Dosage</th>
<th>Remarks</th>
<th>Was This Medication Self Administered?</th>
<th>Signature of Person Observing or Administering Medication</th>
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*Medication authorization form must be used as either a two-sided document or attached first and second page.

☐ Authorization form is complete

☐ Medication is appropriately labeled

☐ Medication is in original container

☐ Date on label is current

Person Accepting Medication (print name) _________________________ Date _____ / _____ / _____