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 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
EMERGENCY HEALTH CARE PLAN

ALLERGY TO: ____________________________________________________________

Child's Name: ___________________ DOB: _______

Child Care Provider __________________

History of Asthma □ Yes (high risk for severe reaction) □ No

Signs of an allergic reaction include:

<table>
<thead>
<tr>
<th>Systems</th>
<th>Symptoms</th>
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<tbody>
<tr>
<td>MOUTH</td>
<td>Itching &amp; swelling of lips, tongue, or mouth</td>
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<tr>
<td>*THROAT</td>
<td>Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough</td>
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<tr>
<td>SKIN</td>
<td>Hives, itchy rash, and/or swelling about the face or extremities</td>
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<tr>
<td>GUT</td>
<td>Nausea, abdominal cramps, vomiting and/or diarrhea</td>
</tr>
<tr>
<td>*LUNG</td>
<td>Shortness of breath, repetitive coughing, and/or wheezing</td>
</tr>
<tr>
<td>*HEART</td>
<td>Weak, irregular pulse, &quot;passing-out&quot;</td>
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</tbody>
</table>

The severity of symptoms can quickly change.
*All of the symptoms listed above can potentially progress to a life-threatening situation.

ACTION:
If ingestion or insect sting is seen or suspected:
(Prescriber should number in order all appropriate actions)

1. __________ Observe child for severe symptoms
2. __________ Administer EpiPen® or Auvi-Q® before symptoms occur
3. __________ Administer EpiPen® or Auvi-Q® if symptoms occur
4. __________ Administer Benadryl® (dose) __________ or Atarax® (dose) __________
5. __________ Call 911 (and request a paramedic) and transport to ER if symptoms occur
6. __________ Call 911 (and request a paramedic) and transport to ER if EpiPen® or Auvi-Q given

Nearest hospital: _______________________________________________________

DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL 911
EVEN IF PARENTS OR PRESCRIBER CANNOT BE REACHED

Parent Signature ___________________ Date __________
Prescriber Signature MD/APRN/PA ___________________ Date __________

Address ___________________________
Phone ___________________________

<table>
<thead>
<tr>
<th>EMERGENCY CONTACTS</th>
<th>TRAINED STAFF MEMBERS</th>
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<tbody>
<tr>
<td>1. __________________</td>
<td>Room,__________</td>
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<tr>
<td>Relation: __________</td>
<td>Phone _________</td>
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<td>Room,__________</td>
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For children with multiple allergies, use one form for each allergen
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 if the medication is a controlled drug, the medication before any medications are administered. Medications must be in the original container and labeled with the 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 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 setting, 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**: 

<table>
<thead>
<tr>
<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**: 

---

*Blank cells can be used for additional information.*
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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 ______/____/____

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Parent/Guardian Signature __________________________________________ Relationship ________ Date ______/____/____

Parent/Guardian’s Address __________________________________________ Town __________________________ State __________________________

Home Phone # (____) ________ Work Phone # (____) ________ Cell Phone # (____) ________

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