Program Participation Packet

Required for children under 18 enrolling in MAC programs

Welcome to MAC! We are happy to welcome your children to our programs. This packet includes policy information and forms that will ensure the safety of the young student. Please read, initial and/or fill out forms as necessary. One form per child is required for the Medical Information and related medical forms, or where information for that child is unique. All forms marked with a * are required by the start of child's class, or the child will not be able to participate. We appreciate your attention to them.

1. Emergency Contacts Form*
2. Medical Information Form*
4. Pick Up Authorization Form*
5. Publicity Consent Form*
6. Medication Administration Policy
7. Authorization for Administration of Medication
8. Emergency Health Care Plan
9. Medication Administration Report (MAR)

Mail or deliver completed forms to:
Education Department, Mystic Arts Center
9 Water Street, Mystic, CT 06355
Or Fax to: 860.536.0610
Emergency Contacts Form*

Name of Child

(First) (Last)

In the event of an emergency, Mystic Arts Center staff will make every effort to first contact the parent or guardians of the child.

Name of Parent/Guardian

(First) (Last)

Phone Numbers

1. ___________________________ Type: □ home □ work □ cell

2. ___________________________ Type: □ home □ work □ cell

In the case that we are unable to reach you, you give the following people permission to take responsibility for your child, including pick up if necessary:

Main Contact

Name ________________________________

(First) (Last)

Relation to Child

□ Parent/legal guardian □ Other Family

□ Neighbor/Friend □ Other ________________________________

Phone Numbers

1. ___________________________ Type □ home □ work □ cell

2. ___________________________ Type □ home □ work □ cell

Secondary Contact (optional)

Name ________________________________

(First) (Last)

Relation to Child

□ Parent/legal guardian □ Other Family

□ Neighbor/Friend □ Other ________________________________

Phone Numbers

1. ___________________________ Type □ home □ work □ cell

2. ___________________________ Type □ home □ work □ cell
Medical Information Form*

Knowing more about your child helps our instructors to tailor their teaching and classroom management and to respond appropriately in cases of emergency.

**Name of Child**
(First) ___________________________________________ (Last) ______ / ______ / ______

**Health Insurance Provider and Member ID#**

Provider Name ________________________________________
Member ID # _________________________________________

**Name and Phone Number of Primary Care Physician**

(First) ___________________________________________ (Last) __________________________

Phone Number _______________________________________

Does your child have any medical conditions we should know about? ☐ YES ☐ NO If yes, please explain:

______________________________________________________________________________

Has your child been recently hospitalized for any reason?

______________________________________________________________________________

Is your child receiving any medication? (This information is helpful for emergency personnel)
☐ YES ☐ NO If yes, please explain:

______________________________________________________________________________

Please list any allergies including food, insects, and drugs

______________________________________________________________________________

Is there anything else you’d like us to know that will help our instructors with your child?

______________________________________________________________________________

If my child becomes ill or is injured and I cannot be contacted, I authorize the Mystic Arts Center staff to call for emergency medical transport and I authorize medical personnel to treat my child. I accept responsibility for any expenses incurred in the medical treatment.
☐ YES ☐ NO

**Name of Parent/Guardian (please print)**

__________________________________________ Date ______ / ______ / ______
(First) ___________________________________________ (Last) __________________________

__________________________________________
Behavior Policy*

Mystic Arts Center faculty and staff will review behavior expectations with students before and during classes. However, MAC reserves the right to dismiss a student for problematic behavior that results in the repeated disruption of class or for disrespect of persons and/or property. Threat, violence or the risk of violence will not be tolerated.

I have read the above behavior policy. I agree that my child will follow the instructions of the Mystic Arts Center staff and faculty and will treat other individuals with courtesy and respect. I understand that if my child fails to do so, he/she will not be allowed to participate in the program and no refund will be issued.

Initials ______________________  Date _____/_____/_____

Pick Up/Child Release Policy*

I (the parents/legal guardians) understand I must arrange for my child/children to be picked up on time from class at the Mystic Arts Center. I realize that MAC does not have an aftercare program and teaching faculty & staff should not be left responsible for children after the close of the scheduled program.

If outstanding circumstances prevent prompt pick-up, I or people acting on my behalf agree to call MAC before the end of the class to inform staff of a reasonable arrival time, even if I have to arrange an alternate pick-up plan.

Lastly, I understand that MAC reserves the right to charge a late fee to parents/legal guardians who are late. After a grace period of five (5) minutes, I understand I will be charged $5 for each ten (10) minutes late that I arrive (including the grace period). The credit card number below may be charged for this reason, or I will make arrangements to pay by cash/check.

If I fail to call MAC, my given emergency contacts cannot be reached by MAC staff, and/or my child is not picked up, I understand MAC may turn my child over to the Groton Police and report the child as “abandoned.”

Initials ______________________  Date _____/_____/_____

Name of Parent/Guardian (please print)

__________________________________________________________________________

(First)__________________________________________________________________________   (Last)

Visa/MC ____________________________________________________________________________   Exp  ___ ___ / ___ ___
Child Release Authorization Form*

Name of Child
(First) (Last)

All authorized persons will be asked to present a photo ID upon pick-up. This list may be changed or added to at any date with written notice. The following people have permission to pick up this child from Mystic Arts Center programs:

<table>
<thead>
<tr>
<th>Name</th>
<th>(First)</th>
<th>(Last)</th>
</tr>
</thead>
</table>

Phone Numbers
1. ___________________________ Type □ home □ work □ cell
2. ___________________________ Type □ home □ work □ cell

Name:
(First) (Last)

Phone Numbers
1. ___________________________ Type □ home □ work □ cell
2. ___________________________ Type □ home □ work □ cell

Name
(First) (Last)

Phone Numbers
1. ___________________________ Type □ home □ work □ cell
2. ___________________________ Type □ home □ work □ cell

Self-Release Consent (for students over the age of twelve years)

Selective release:
This student has permission by the parent/legal guardian to find his/her own transportation at the completion of a class only on select days as noted by the parent/legal guardian.

☐ YES ☐ NO Dates authorized

Full release:
This student has permission by the parent/legal guardian to leave at the completion of a class and find his/her own transportation. ☐ YES ☐ NO

Name of Parent/Guardian (please print)

(First) (Last) Date _____/_____/_____

* Please print all forms legibly and completely.
Publicity Consent Form*

Name of Child

(First) (Last)

I grant the Mystic Arts Center permission for use of photographs and/or images of my child and/or his or her artwork for educational, publicity, archival, or grant purposes. These images will be in print, media or broadcast formats. I understand that written requests denying this must be given at the time of registration or before the first day of class by the parent/legal guardian of student.

☐ I accept ☐ I refuse

Name of Parent/Guardian (please print)

(First) (Last)

Signature

Date _____/_____/______
Medication Acceptance & Administration Policy

Mystic Arts Center is not required by law to accept or administer any medications, prescription, or non-prescription. However, we are licensed to administer the Epipen and can be available to do so for select programs with advance notice. Parents/guardians requesting Epipen administration while at a MAC program shall provide Education staff with the appropriate written authorization and the medication before any administration can occur. Other medications cannot be accepted or administered; arrangements should be made for the child to have medication either before or after the MAC program.

Acceptance of Epipen

- Epipens are to be accepted by a MAC staff member who is trained to administer medication.
- Epipens must be in the original container with a pharmacy label displaying the child’s name, name of medication, directions for medication’s administration, and date of prescription.
- Each Epipen must have an accompanying Authorization for the Administration of Medication form provided by the Mystic Arts Center, which has been completed and signed by the prescriber and signed by the parent.
- Each Epipen must have an accompanying Medication Administration Record (MAR) form provided by the Mystic Arts Center, with portion completed by parent/guardian.
- Each Epipen must have an accompanying Emergency Health Care Plan form, available from Mystic Arts Center, and completed and signed by guardian.
- Epipens must be inspected to be certain the requirements have been met. Accepting staff member must then sign and date the Authorization for the Administration of Medication and Medication Administration Record forms.

Care and Administration of Epipen

- All medication is to be stored in its original packaging.
- Student may carry emergency medication (Epipen) only with written permission of the parent. It must stay with the child at all times.
- Medication can only be administered by a Mystic Arts Center staff member who has been trained and certified to do so.
- After giving medication to the student, it must be logged onto the Medication Administration Record (MAR) by trained MAC staff or faculty.
- Unused and/or expired medication is to be returned to the legal guardian of the student upon completion of the class session. Unclaimed medication will be safely locked and stored, and will be destroyed 1 week after the program ends unless claimed by the guardian.

Forms Check List for Administration of Epipen

- Complete Authorization for the Administration of Medication form, with prescriber
- Complete Emergency Health Care Plan, with prescriber
- Complete top lines of Medication Administration Record
Authorization for the Administration of Medication

Medications must be in original container and labeled with the child’s name, name of medication, directions for medication’s administration, and date of the prescription. All unused medication shall be destroyed if not picked up within one week of the end of that MAC program.

**Authorized Prescriber’s Order**
(Physician, Physician Assistant, Advance Practice Registered Nurse)

<table>
<thead>
<tr>
<th>Name of Child</th>
<th>Date of Birth _/<strong>/</strong></th>
<th>Today’s Date _/<strong>/</strong></th>
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<table>
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<tr>
<th>Medication Name</th>
<th>Controlled Drug _ yes _ no</th>
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<tr>
<th>Dosage</th>
<th>Method</th>
<th>Time of Administration</th>
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Specific Instructions for Medication Administration ____________________________________________

Medication Administration: Start Date _/__/__ End Date _/__/__

Is this medication to be self-administered by the child? _ yes _ no

Relevant Side Effects of Medication ______________________________________________________________

Plan of Management for Side Effects __________________________________________________________

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<th>Known Food Allergies?</th>
<th>Reactions to?</th>
<th>Interactions with?</th>
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<td>Yes</td>
<td>No</td>
<td>Yes</td>
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</table>

Explain “Yes” from above _______________________________________________________________

Prescriber’s Name ___________________________________________ Phone _______________________

Prescriber’s Address _________________________________________

Prescriber’s Signature _______________________________________

**Parent/Guardian Authorization:** I request that medication be administered to my child as described and directed above while attending programs at the Mystic Arts Center.

<table>
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<tr>
<th>Child’s Name</th>
<th>Today’s Date</th>
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Child’s Address ____________________________________________

Parent/Guardian authorizing administration of medication as described and directed above:

<table>
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<tr>
<th>Name _______________</th>
<th>Relationship to Child</th>
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</table>

Address ___________________________________________________

**Signature of Parent/Guardian authorizing administration of medication** ____________________________________________

**Signature of Staff receiving written authorization and medication** ____________________________________________

Title/Position ___________________________ Name ____________________________
Emergency Health Care Plan

Name of Child ____________________________________________ (Last)  

Allergy to ______________________________________________ Date of Birth: _____ / _____ / _____  

History of Asthma  □ Yes □ No  

Trained Staff Member(s) ____________________________________  

Signs of allergic reaction include:  

Systems          Symptoms  
Mouth            itching & swelling of lips, tongue, or mouth  
Throat*          itching and/or a sense of tightness in the throat, hoarseness, and hacking cough  
Skin             hives, itchy rash, and/or swelling about the face or extremities  
Gut              nausea, abdominal cramps, vomiting and/or diarrhea  
Lung*            shortness of breath, repetitive coughing and/or wheezing  
Heart*           thready pulse, fainting  

The severity of symptoms can quickly change. *Symptoms may progress to a life-threatening situation.  

If ingestion of insect sting is seen or suspected:  
(prescriber, please number in order of all appropriate actions)  

___ Observe child for severe symptoms  
___ Administer Epipen before symptoms occur  
___ Administer Epipen if symptoms occur  
___ Call 911 (and request a paramedic) and transport to ER if symptoms occur  
___ Call 911 (and request a paramedic) and transport to ER if Epipen given  

Preferred Hospital  

Name ________________________________________________ City/Town/State  

Emergency Contacts  

Name: ________________________________________________  

(First) ____________________________ (Last) ____________________________  

Relation to Child:  
□ Parent/legal guardian □ Other Family □ Neighbor/Friend □ Other ____________________________  

Phone Number ____________________________________________ Type □ home □ work □ cell  

Name: ________________________________________________  

(First) ____________________________ (Last) ____________________________  

Relation to Child:  
□ Parent/legal guardian □ Other Family □ Neighbor/Friend □ Other ____________________________  

Phone Number ____________________________________________ Type □ home □ work □ cell  

Signature of Parent/Guardian Authorizing Administration of Medication  

__________________________________________ Date _____ / _____ / _____  

Signature of Prescriber (MD/APRN/PA)  

__________________________________________ Date _____ / _____ / _____  

Prescriber Address/Phone ____________________________________________
Medication Administration Report (MAR)

Please complete the first three lines on this form before returning it to the Mystic Arts Center.

Name of Child ________________________________ Date of Birth _____ / _____ / _____
Pharmacy Name ______________________________ Prescription Number _______________________
Medication Name ______________________________

___ Authorization form complete  ___ Medication is appropriately labeled
___ Medication is in original container  ___ Date on label is current

Staff Accepting Medication (print) ______________________________ Date _____ / _____ / _____

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<th>Date</th>
<th>Time</th>
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<th>Remarks</th>
<th>Was this medication self-administered?</th>
<th>Signature of person observing or administering medication</th>
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