

# MYSTIC MUSEUM OF ART

## **Program Participation Packet**

*Required for children under 18 enrolling in MMoA programs*

Welcome to MMoA! We are happy to welcome your children to our studio programs. This packet includes policy information and forms that will ensure the safety of your child. Please read, initial and/or sign forms where applicable. One form per child is required on all medical related forms, or where information for that child is unique. All forms marked with a \* are required by the start of class or by the first day of camp, to allow participation.

**1. Emergency Contacts Form\***

**2. Medical Information Form\***

**3. Behavior Policy\*/ Pick up and Release Policy\*/ Publicity Consent\***

*If applicable:*

**4. Medication Administration Policy**

**5. Authorization for Administration of Medication**

**6. Emergency Health Care Plan**

**7. Medication Administration Report (MAR)**

Mail or deliver completed forms to:  
Education Department, Mystic Museum of Art  
9 Water Street, Mystic, CT 06355  
Or Fax to: 860.536.0610

Rev. 2021.05

# MYSTIC MUSEUM OF ART

## Emergency Contacts Form\*

### Name of Child:

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First

Last

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

### Name of Parent/Guardian:

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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:

1. \_\_\_\_\_  
Name                                      Phone Number                                      Relationship to child

2. \_\_\_\_\_  
Name                                      Phone Number                                      Relationship to child

3. \_\_\_\_\_  
Name                                      Phone Number                                      Relationship to child

# MYSTIC MUSEUM OF ART

## Medical Information Form\*

### Name of Child:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
First Last Birthdate

### Primary Care Physician:

\_\_\_\_\_  
Name Phone Number

### Health Insurance:

\_\_\_\_\_  
Provider Name Member ID #

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?

\_\_\_\_\_

Does your child take medication regularly? YES NO If yes, please explain:

\_\_\_\_\_

Please list any allergies including food, insects, and drugs:

\_\_\_\_\_

Is there anything else, medically related, that we should know about 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)

\_\_\_\_\_  
First Last Date \_\_\_\_/\_\_\_\_/\_\_\_\_

# MYSTIC MUSEUM OF ART

## Behavior Policy\*

Mystic Museum of Art faculty and staff will review behavior expectations with students before and during classes. However, MMoA 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. I understand that if my child fails to follow behavioral guidelines, he/she will not be allowed to participate in the program and no refund will be issued.

Initials: \_\_\_\_\_

## 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 Museum of Art. If outstanding circumstances prevent a timely pick-up, I agree to call MMoA before the end of the class to inform staff of an alternate pick up plan. I understand that MMoA 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).

Initials: \_\_\_\_\_

## Child Release Authorization\*

All authorized persons will be asked to present a photo ID upon pick-up. The following people have permission to pick up this child from Mystic Museum of Art programs:

1. \_\_\_\_\_  
Name Phone Number Relationship to Child
2. \_\_\_\_\_  
Name Phone Number Relationship to Child

## Self-Release Consent (12 years and older)

This student has permission by the parent/legal guardian to leave at the completion of a class and find his/her own transportation, or to walk home: YES NO

Name of Parent/Guardian (please print)

\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Last

## Publicity Consent\*

I grant the Mystic Museum of Art permission for use of photographs and/or images of my child and/or their artwork for educational, publicity, archival, or grant purposes. These images will be in print, media, or broadcast formats.

*I accept*

*I refuse*

Name of Parent/Guardian (please print)

\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Last

# MYSTIC MUSEUM OF ART

## EpiPen Acceptance & Administration Policy

Mystic Museum of Art 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 MMoA 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, and arrangements should be made for the child to have medication either before or after the program.

### Acceptance of EpiPen

- EpiPen's are to be accepted by a MMoA staff member who is trained to administer medication.
- EpiPen's 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 Museum of Art, which has been completed and signed by the prescriber and signed by the parent or guardian.
- Each EpiPen must have an accompanying *Medication Administration Record* form provided by the Mystic Museum of Art.
- Each EpiPen must have an accompanying *Emergency Health Care Plan* form, available from Mystic Museum of Art, and completed and signed by the parent or guardian.
- The 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.
- Medication can only be administered by a MMoA 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 MMoA 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.

### 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*

# MYSTIC MUSEUM OF ART

## 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.

### Authorized Prescriber's Order (to be completed by the Physician, PA, or APRN)

Name of Child \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Medication Name \_\_\_\_\_

Dosage \_\_\_\_\_ Method \_\_\_\_\_

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:

\_\_\_\_\_  
\_\_\_\_\_

Prescriber's Name \_\_\_\_\_ Phone \_\_\_\_\_

Prescriber's Address \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Child's Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

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

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_ Date \_\_\_\_\_

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Name of MMoA Staff member receiving Authorization form: \_\_\_\_\_

Title/Position of MMoA Staff member: \_\_\_\_\_

Signature: \_\_\_\_\_

# MYSTIC MUSEUM OF ART

## Emergency Health Care Plan

Name of Child: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Allergy to: \_\_\_\_\_

History of Asthma: Yes \_\_\_\_ No \_\_\_\_

### Signs of allergic reaction include:

- mouth itching & swelling of lips, tongue, or mouth
- itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
- hives, itchy rash, and/or swelling about the face or extremities
- nausea, abdominal cramps, vomiting and/or diarrhea
- shortness of breath, repetitive coughing and/or wheezing
- rapid pulse, fainting

\*Symptoms may progress to a life-threatening situation.

### If an allergic reaction is seen or suspected:

(prescriber, please place a X next to all appropriate actions)

\_\_\_\_ Observe child for severe symptoms

\_\_\_\_ 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: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address of Hospital: \_\_\_\_\_

### Emergency Contacts:

1) Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

2) Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

3) Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

### Signature of Parent/Guardian Authorizing Administration of Medication:

\_\_\_\_\_ Date \_\_\_\_\_

### Signature of Prescriber (MD/APRN/PA):

\_\_\_\_\_ Date \_\_\_\_\_

Prescriber Address: \_\_\_\_\_

Prescriber's Phone #: \_\_\_\_\_

# MYSTIC MUSEUM OF ART

## 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: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

Medication Name: \_\_\_\_\_

Staff Accepting Medication (print) \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_ Authorization form complete      \_\_\_\_ Medication is appropriately labeled

\_\_\_\_ Medication is in original container      \_\_\_\_ Date on label is current

Date	Time	Dosage	Remarks	Self-administered?	Staff Initials