Mystic Museum of Art

Program Participation Packet

Required for children under 18 enrolling in MMA programs

Welcome to MMoA! 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*
3. Behavior & Pick Up/Child Release Policies*
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 Museum of Art
9 Water Street, Mystic, CT 06355
Or Fax to: 860.536.0610

MYSTIC MUSEUM OF ART

Emergency Contacts Form*

Name of Child

_____

(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

_____

(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

MYSTIC MUSEUM OF ART

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) Birthdate

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 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 Museum of Art 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) Birthdate

Mystic Museum of Art

Behavior Policy*

Mystic Museum of Art faculty and staff will review behavior expectations with students before and during classes. However, MMA 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 Museum of Art 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 Museum of Art. I realize that MMA 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 MMA 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 MMA 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.

Initials _____ Date ___/___/____

Name of Parent/Guardian (please print)

_____

(First) (Last)

CCs _____ Exp. ___ ___ / ___ ___

MYSTIC MUSEUM OF ART

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 Museum of Art programs:

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

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)

_____ Date _____/_____/_____

(First) (Last)

Mystic Museum of Art

Publicity Consent Form*

Name of Child:

_____

(First) (Last)

I grant the Mystic Museum of Art 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 ___/___/___

Mystic Museum of Art

Medication 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 MMA 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 MMoA program.

Acceptance of Epipen

- Epipens are to be accepted by a MMoA 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 Museum of Art, 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 Museum of Art, with portion completed by parent/guardian.
- Each Epipen must have an accompanying *Emergency Health Care Plan* form, available from Mystic Museum of Art, 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 Museum of Art 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.

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*

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. All unused medication shall be destroyed if not picked up within one week of the end of that MMoA program.

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

Name of Child _____ **Date of Birth**: ___/___/___

Today's Date: ___/___/___

Medication Name:_____ **Controlled Drug:** ☐ Yes ☐ No

Dosage: _____ **Method:** _____
Time of Administration: _____

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:

_____

Known Food Allergies?	Reactions to?	Interactions with?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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 Museum of Art.

Child's Name: _____ **Today's Date:** _____

Child's Address: _____

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

Name: _____

Relationship to Child: _____

Address: _____

Signature of Parent/Guardian authorizing administration of medication

_____

Signature of Staff receiving written authorization and medication

_____

Title/Position: _____

Name: _____

MYSTIC MUSEUM OF ART

Emergency Health Care Plan

Name of Child: _____
(First) (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
_____

Mystic Museum of Art

Medication Administration Report (MAR)

Please complete the *first three lines* on this form before returning it to the Mystic Museum of Art.

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: _____ / _____ / _____

Date	Time	Dosage	Remarks	Was this medication self-administered?	Signature of person observing or administering medication
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	