WINDSOR MONTESSORI SCHOOL & DISCOVERY CENTER

2021 Summer Registration Instructions:

Current Operating hours and group size (16) are subject to change based on COVID restrictions being lifted for the 2021 Summer.

INITIAL REGISTRATION: In order to secure a spot for your child, simply....

Turn in the completed packet. This includes:

Summer Program Registration Form.

Care4Kids Paperwork (if necessary).

Parent Financial Agreement

Parent Permission Form

Health Assessment- Completed by Parent. (1st Page of Physical/Kindergarten-4th Grade ONLY)

Immunization Record and Physical within last 12 months (Kindergarten-4th Grade ONLY)

Related Medical Care Plans- Must be completed by Guardian & Physician.

Medication Authorization- Must be completed by Guardian & Physician.

Pay a deposit of half of the total cost of all sessions that your child is registered for.

Pay a non-refundable $25 registration fee per child.

Your child's spot will *NOT* be confirmed for our Summer Program until this packet is 100% completed and submitted with payment.

ADDING/CHANGING SESSIONS:

You have until May 28th to make any changes requiring a partial or full refund.
After May 28th no refunds will be issued.
Please contact me with any questions you may have: 860.285.1420
Casey@townofwindsorct.com

IMPORTANT DEADLINES

Session Dates	Care4Kids Deadline (In order to apply for Care4Kids, we ask for your paperwork to be completed by these dates)	Half of the Total Tuition and $25 Reg Fee Due	Second Half of Tuition Due
June 21 - 25	5/21/2021	**At Registration**	**5/28/2021**
June 28- July 1	5/28/2021		
July 5 - 9	6/5/2021		
July 12 - 16	6/12/2021		
July 19 - 23	6/19/2021		
July 26 - 30	6/26/2021		
August 2 - 6	7/2/2021		
August 9 - 13	7/9/2021		
August 16 – 20	7/16/2021		

WINDSOR MONTESSORI SCHOOL & DISCOVERY CENTER

Child & Parent Information

Child's First Name:	Last Name:

Address: _____
Street City State Zip Code

Grade (Fall 2020): School Attending:

Birth Date: Age: Gender: Male Female

Can your Child Swim? ☐ Yes ☐ No
If NO, I will provide a US Coast Guard Certified Life Jacket _____ (please initial)

Child's T-Shirt Size (Youth): ☐ X-Small ☐ Small ☐ Medium ☐ Large ☐ X-Large

1. Parent First Name:	Last Name:

Address:
_____
Street City State Zip Code

Phone (Cell/Home) #:	Work #:
Employer:	Address:

Email Address:

2. Parent First Name:	Last Name:

Address:
_____
Street City State Zip Code

Phone (Cell/Home) #:	Work #:
Employer:	Address:

Email Address:

NEXT PAGE →

Summer Program Sessions

WINDSOR MONTESSORI SCHOOL & DISCOVERY CENTER

Please select the Summer Program and Sessions you wish to attend:	
☐ Session 1: June 21 – 25, 2021	☐ Session 6: July 26 – 30, 2021
☐ Session 2: June 28 – July 1, 2021 (Closed July 2nd)	☐ Session 7: August 2 – 6, 2021
☐ Session 3: July 5 – 9, 2021	☐ Session 8: August 9 – 13, 2021
☐ Session 4: July 12 – 16, 2021	☐ Session 9: August 16 – 20, 2021
☐ Session 5: July 19 – 23, 2021	☐ Session 10: August 23 – 27, 2021 **CHILD CARE FOR INTERNAL FAMILIES ONLY**

Primary (Ages 3 & 4/***Fully Potty Trained***)	☐ 8:30-12:00 $170	☐ 7:30-4:30 $295 ☐ 8:00-5:00 $295
K-1st Grade (Must be 5 Years Old)	☐ 8:30-4:30 $245	☐ 7:30-4:30 $265 ☐ 8:00-5:00 $265
2nd- 4th Grade	☐ 8:30-4:30 $245	☐ 7:30-4:30 $265 ☐ 8:00-5:00 $265

****Please note payment schedule on registration packet cover sheet****

We offer a 10% sibling discount on the lower tuition.

Emergency Contacts

1. First Name:	Last Name:
Relationship:	Phone #:

Address: _____
Street City State Zip Code

☐ Yes, the person above can pick my child up. ☐ No, the person above can't pick my child up.

2. First Name:	Last Name:
Relationship:	Phone #:

Address: _____
Street City State Zip Code

☐ Yes, the person above can pick my child up. ☐ No, the person above can't pick my child up.

Child's Health Information

Does your child have any Allergies? ☐ Yes ☐ No
List allergy(ies): _____

Is your child currently taking Medication? ☐ Yes ☐ No For what condition: _____
If YES, will your child need this medication at Summer Program? ☐ Yes ☐ No

If medication is needed a Medical Authorization form completed by a doctor is required to register.
A Care Plan completed by a doctor is required for an Asthma/Allergy treatment.
Please review and complete Pages 10-12 as medically necessary.

Medication name:

NEXT PAGE →

Student Physical Pages 7-9 Required for all enrollees

Medical authorizations pages 10-12 complete as necessary.

Please tell us about your child.

Who does your child live with_____

Siblings: Please list all siblings (including step-siblings), current ages and gender:

1._____ M F AGE _____

2._____ M F AGE _____

3._____ M F AGE _____

Are there any family events or recent changes that you feel have impacted your child? YES NO

If yes, please describe:_____

_____

Any reasons you feel your child might have difficulty functioning in a group size with a 1 to 10 ratio? YES NO

If yes, please describe

_____

_____

Please describe the nature of your child's personality and observed self-esteem:

_____

_____

What are your child's favorite activities/interests?

_____

_____

What are your child's strengths?

_____

_____

Does your child have any challenges or behaviors that may be difficult to handle? YES NO

If yes, please describe how you address them: _____

_____

_____

Does your child have a 504, IEP, and/or Behavioral Plan at their current school? YES NO

If yes, please describe (This information is required by our license.) :

_____

_____

_____

NEXT PAGE →

Please use the space below to include any additional information that you think we should be aware of to ensure your child has a successful summer experience!

WINDSOR MONTESSORI SCHOOL & DISCOVERY CENTER

_____

_____

_____

_____

_____

_____

_____

_____

_____.

Emergency Care Authorization

I certify that I am the parent or legal guardian of the child named above and give consent for emergency medical care, surgical treatment, and/or transportation to a care facility should my child's condition require it in my absence. I understand that time and conditions permitting, reasonable attempts will first be made to contact me and any designated representatives in such case. I hereby assume all financial responsibility for such actions taken on the behalf of my child.

Parent/Legal Guardian's Signature: _____ Date: _____

Office Use Only

Please check all forms are completed. Date Received _____ TIME:_____

☐ Registration Form ☐ Parent Permission
☐ Physical ☐ Allergy Care Plan NA
☐ Medication Authorization ☐ Asthma Care Plan NA

Payment at Registration

Number Of Sessions	Weekly Rate	½ Total & Registration Fee Due ($25 per child)	Amount Due 5/28/2021

Sibling discount applied 10% _____

Received by: _____ Date: _____

Confirmation Sent:_____
By:_____

WINDSOR MONTESSORI SCHOOL & DISCOVERY CENTER

Parent/Guardian Permission

I _____, grant the following permissions for my child _____.

FIELD TRIP PERMISSION: To participate in field trips, on foot or in an authorized vehicle, as scheduled and posted by Windsor Discovery Center.

RELEASE OF INFORMATION: I hereby give permission for my child's name, address, and telephone number to be included in the classroom list distributed to other Windsor Discovery Center parents.

PHOTO PERMISSION: I hereby consent that Windsor Montessori School and Discovery Center and the Town of Windsor or any person authorized by the Town may use photographic, social media, videotape images and/or voice recordings, and classroom work in which my child may be included in whole or in part for any purpose they find appropriate such as promotional marketing material and posts on social media like Facebook, Twitter, Instagram, and Youtube.

Parent's Signature:_____ Date: _____

MEDICAL/FIRST AID TREATMENT: I hereby give permission for my child to receive first aid treatment for minor injuries from Windsor Discovery Center staff. Written permission is required for the application of any topical ointments and all prescription medications.

Parent's Signature:_____Date:_____

BEHAVIOR PLAN/CHILD DISCIPLINE POLICY: The school's behavior plan (Parent Handbook Pg. 17) has been discussed with me upon registration. I've had an opportunity to review and ask any related questions. I understand the school uses a positive discipline approached and redirection. If my child's behavior requires additional support, I will be involved in the process of creating an individualized behavior plan for my child. I understand my child may be asked to leave the program as a result of "Serious Acts of Aggression" as outlined in the Behavior Management Procedures.

Parent's Signature:_____ Date:_____

State of Connecticut Department of Education
Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part 1 — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

❑ I have reviewed the health history information provided in Part 1 of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height** _____ in. / _____% ***Weight** _____ lbs. / _____% **BMI** _____ / _____% **Pulse** _____ ***Blood Pressure** _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**			***Auditory Screening**			History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	Date
Type:	Right	Left	Type:	Right	Left		
With glasses	20/	20/		❑ Pass	❑ Pass	***HCT/HGB:**	
Without glasses	20/	20/		❑ Fail	❑ Fail	***Speech** (school entry only)	
❑ Referral made			❑ Referral made			Other:	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

Anaphylaxis ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source

Allergies *If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: _____
Daily Medications (*specify*): _____

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: _____

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: _____

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

_____

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	**Normal**	**Referral Made:**
Completed by: ❑ Dentist	Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) _____ _____ _____ _____ _____	❑ Yes ❑ No
Risk Assessment	**Describe Risk Factors**		
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other _____	❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ Other _____	

Recommendation(s) by health care provider: _____

_____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

_____

Signature of Parent/Guardian Date

Signature of health care provider	DMD / DDS / MD / DO / APRN / PA / RDH	Date Signed	Printed/Stamped ***Provider*** Name and Phone Number

Student Name: _____ Birth Date: _____ HAR-3 REV. 7/2018

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required 7th-12th grade	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Exemption: Religious _____ **Medical:** Permanent _____ Temporary _____ **Date:** _____

Renew Date: _____ _____ _____ _____

Religious exemption documentation is required upon school enrollment and then renewed at 7th grade entry.
Medical exemptions that are temporary in nature must be renewed annually.

Immunization Requirements for Newly Enrolled Students at Connecticut Schools (as of 8/1/17)

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through 11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

Initial/Signature of health care provider	MD / DO / APRN / PA	Date Signed	Printed/Stamped ***Provider*** Name and Phone Number

9a.

WINDSOR MONTESSORI SCHOOL & DISCOVERY CENTER

ALLERGY ACTION PLAN

Patient Name: _____ Date of Birth: _____ Age: _____

Allergies: _____

Asthma: ☐ Yes (High Risk for Severe Reaction) ☐ No

Additional health problems: _____

Concurrent Medications: _____

SIGNS OF AN ALLERGIC REACTION

MOUTH	Itching, swelling of lips and/or tongue
THROAT*	Itching, tightness/closure, hoarseness
SKIN	Itching, hives, redness, swelling
GUT	Vomiting, diarrhea, cramps
LUNGS*	Shortness of breath, cough, wheeze
HEART	Weak pulse, dizziness, passing out

Only a few symptoms may be present. Severity of symptoms can change quickly.

**Some symptoms can be life-threatening.*

ACT FAST! Initiate Emergency Action Plan if symptoms occur.

Emergency Action Steps – DO NOT HESITATE TO GIVE EPINEPHRINE!

Action for Minor Reaction:

1. If only symptom (s) are: _____,give_____
2. Then call parent/guardian_____Phone#_____

Action for Major Reaction:

1. If symptom(s) are: _____
   _____
2. Give_____
3. CALL **911**
4. Call Parent/Guardian_____ Phone#_____
5. If Parent/Guardian is unreachable, contact emergency contacts on the enrollment form.

Medication Requirements: (Check One)

1._____ No medication required while attending program. Physicians initials required:_____

2._____ Medication required at the program (Bring original prescription to the first day of the program, with original prescription label adhered to medication)

ALL MEDICATIONS MUST HAVE A COMPLETED AUTHORIZATION FOR ADMINISTRATION OF MEDICATION.

Health Care Provider Signature_____ Date:_____

Parent/Guardian Signature _____ Date:_____

WINDSOR MONTESSORI SCHOOL & DISCOVERY CENTER

ASTHMA MEDICATION AUTHORIZATION AND ASTHMA ACTION PLAN

Parent/Guardian: Complete and Sign this portion and the medication authorization below **Today's Date:**

Student Name:	Date of Birth	
Address:		
Parent/Guardian:	Home/Cell #:	Work #:
Health Care Provider:	Office #:	

① **KNOWN ASTHMA TRIGGERS**: ❑ Exercise ❑ Pet Dander ❑ Mold ❑ Dust ❑ Pollen ❑ Colds ❑ Strong Odors ❑ Cold Air ❑ Pests

② **ALLERGIES:**

HEALTH CARE PROVIDER: COMPLETE ALL ITEMS IN SHADED AREA, SIGN, AND DATE.

Asthma Medication(S) To Be Given:

Student's Asthma Severity Classification: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent

Ⓐ **Exercise Pre-treatment**: ❑ Not Required ❑ Before Recess ❑ Before PE/Sports

Give: Albuterol MDI 90 / Xopenex MDI 45____ Puffs Inhaled (by mouth) ❑ **10-15 minutes before exercise** ❑ **with spacer**

(***Circle One***) Nebulized Albuterol 2.5mg/Xopenex 0.63mg Vial inhaled (by mouth) ❑ **10-15 minutes before exercise** ❑ **with a nebulizer**

OTHER:

Ⓑ **RESCUE MEDICINE TO RELIEVE ASTHMA SYMPTOMS: COUGH, CHEST TIGHTNESS, WHEEZING (Follow CAUTION or DANGER ZONES of Asthma Action Plan)**

Give (***Circle One***):

Albuterol MDI 90 / Xopenex MDI 45 _____ Puffs Inhaled (by mouth) ❑ **every ___ hours** ❑ **with spacer**

Nebulized Albuterol 2.5mg OR _____ Vial inhaled (by mouth) ❑ **every ___ hours** ❑ **nebulizer**

Nebulized Xopenex 0.63mg

OTHER:

*** If there is no improvement 20 minutes after taking the Rescue Medication: Notify provider**

HEALTH CARE PROVIDER MEDICATION AUTHORIZATION REQUIRED FOR ALBUTEROL/XOPENEX AS STATED IN ABOVE PLAN, AND IN ACCORDANCE WITH CT LAW AND REGULATIONS 10-212a

③ **Side Effect(s) to watch for:** Nervousness, Shaking, Palpitations, Headache **or** ❑ **None**

④ **Reaction to/or negative interaction with food or drugs:** **or** ❑ **None**

⑤ **Self–Administration Authorization:** ☐ **This student is capable to safely and properly self-administer medication(s)**

Or **This student is N** ☐ **approved to self-administer medication**

Medication Start Date _____/_____/_____ END Date _____/_____/_____ (One Year maximum)

Heath Care Provider Signature_____Date_____

WINDSOR MONTESSORI SCHOOL & DISCOVERY CENTER

ASTHMA MEDICATION PARENTAL CONSENT

PARENT/GUARDIAN CONSENT:

- ❑ I authorize the student to possess and self-administer medication as described and directed above
- ❑ I authorize this medication to be administered by school personnel 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 assume full responsibility for providing the school with the prescribed medication and spacer.
- ❑ I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)

Parent Signature:_____

Date:_____

Staff Receiving Written Authorization and Medication _____

Title/Position:_____

Date: _____

Windsor Montessori School & Discovery Center
Summer Program Registration 2021

Authorization for the Administration of Medication by Child Day Care Personnel

In Connecticut, licensed Child Day Care Centers, Group Day Care Homes, and Family Day Care Homes 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 by daycare staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed. Medications must be in the original container and labeled with the child's name, name of the medication, directions for medication administration, and date of the prescription. All unused medication will be destroyed if not picked up within one week following the termination of the authorized prescriber's order.

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child _____ Date of Birth ____/____/____ Today's Date ____/____/____
Address of Child _____ Town _____
Medication Name/Generic or Drug _____ Controlled Drug? ☐ YES ☐ NO
Condition for which drug is being administered: _____
Special Instructions for Medication Administration _____
Dosage _____ Method/Route _____
Time of Administration _____ If PRN, Frequency _____
Medication Administration 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 _____
School Nurse Signature (if applicable) _____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child 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 _____
Parent/Guardian authorization for self-administration: ☐ YES ☐ NO _____
School Nurse, if applicable, for self-administrati ☐ YES ☐ NO _____

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Today's Date _____ Printed name of Individual Receiving Written Authorization and Medication _____
Title/Position _____ Signature _____ (In INK)