SCHOOL HEALTH SERVICE
MEDICATION REQUEST FORM FOR EPINEPHRINE/ANTIHISTAMINE

Dear parent /guardian,

For Epinephrine/Antihistamine that may need to be administered during the school day, during school-sponsored activities, or while on a school bus or other school property, we must have this form completed by you and by your health care provider. These medications must be supplied by the parent/guardian in their original container(s) from the pharmacy.

Student Name_____Date of Birth_____

Grade_____ Teacher/First Period Teacher_____

Allergic to_____

Epinephrine _____

Dose to be given_____

Frequency/time to be given_____

Antihistamine_____

Dose to be given_____

Frequency/time to be given_____

Student requires supervision: Yes___ No ___

Student can carry and self-administer Epinephrine Yes_____ No_____ Antihistamine Yes___ No___

Keep Medication in Nurses' Office ____ Keep with student in classroom___ Return Medication Home___

Date to stop Medication _____

At the end of the school year, please return my child's medicine by (check one):
☐ Sending it home with my child ☐ Holding all medicine in the clinic to be picked up by parents
(all medicine will need to be picked up no later than 5/22/26)

I give my permission for school personnel to administer prescribed medication listed above. I agree to allow this information to be shared with adults responsible for my child's care. I understand that I am responsible for providing the school with the prescribed Medication in the amount needed and in its original container with label intact as needed by my child. I hereby release Liberty Christian Academy School Board and its employees from any claims or liabilities connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance.

Signature of Parent/Guardian_____ Date_____

Signature of Prescriber _____ Date _____

Printed Name of Prescriber _____

****PRESCRIBER PLEASE COMPLETE THE FOLLOWING PAGE. THANK YOU. ****

FOOD ALLERGY ACTION PLAN

Student's Name _____ Date of Birth _____

Grade _____ Teacher/First Period Teacher _____

Symptoms	**Give Checked Medication**	
If a food allergen has been ingested, but *no symptoms.*	___Epinephrine	___Antihistamine
Mouth : Itching, tingling, or swelling of lips, tongue, mouth.	___Epinephrine	___Antihistamine
Skin : Hives, itchy rash, swelling of the face or extremities	___Epinephrine	___Antihistamine
Gut: Nausea, abdominal cramps, vomiting, diarrhea	___Epinephrine	___Antihistamine
Throat**: Tightening of throat, hoarseness, hacking cough	___Epinephrine	___Antihistamine
Lung**: Shortness of breath, repetitive coughing, wheezing	___Epinephrine	___Antihistamine
Heart**: Weak or thready pulse, low blood pressure, fainting, pale, blueness	___Epinephrine	___Antihistamine
Other**	___Epinephrine	___Antihistamine
**If reaction is progressing (several of the above areas Affected) give:	___Epinephrine	___Antihistamine

** means potentially life-threatening. The severity of symptoms can quickly change.

Signature of Prescriber_____ **Date** _____

Printed Name of Prescriber_____