Timberlake Christian Schools

EPINEPHRINE/ANTIHISTAMINE MEDICATION ADMINISTRATION FORM

For Epinephrine/Antihistamine that may need to be administered during the school day, during school-sponsored activities or while on 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/Home Room Teacher_____

Allergic to_____

Specific past reaction_____

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 _____

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 Timberlake Christian Schools 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. ****

Timberlake Christian Schools

ALLERGY ACTION PLAN

Student Name_____ Date of Birth_____

Grade_____ Teacher/Home Room Teacher_____

Symptom	Give Checked Medication	
If allergen has been ingested or exposure happened, but no symptoms.	____ Epinephrine	____ Antihistamine
Mouth: Itching, tingling, or swelling of lips, tongue, mouth	____ Epinephrine	____ Antihistamine
Skin: Hives, itchy rash, swelling of face or extremities	____ Epinephrine	____ Antihistamine
Gut: Nausea, abdominal cramps,vomiting, diarrhea	____ Epinephrine	____ Antihistamine
Throat:** Tightening of throat, hoarseness, hacking cough	____ Epinephrine	____ Antihistamine
Lungs:** Shortness of breath, repetitive coughing, wheezing	____ Epinephrine	____ Antihistamine
Heart**: weak or thread pulse, low blood pressure, fainting, pale, blueness	____ Epinephrine	____ Antihistamine
Other:**	____ Epinephrine	____ Antihistamine
**If reaction is progressing (several of above areas affected) give:	____ Epinephrine	____ Antihistamine

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

Signature of Prescriber _____ Date _____

Printed Name of Prescriber _____