



SCS ALLERGY ACTION PLAN 2020-21

Action Plan forms are only required if a student has asthma, diabetes, seizures or severe allergies requiring an EpiPen. Section II of this form must be completed by the Physician.

SECTION I – PARENT OR GUARDIAN TO COMPLETE

Student Name: _____

_____	_____	_____	_____
Last	First	Middle	Date of Birth

_____	_____	_____
Parent/Guardian	Cell Phone	Work Phone

_____	_____	_____
Other Emergency Contact	Cell Phone	Work Phone

_____	_____
Treating Physician	Phone

Please list any allergies (including food allergies): _____

Does your child have a severe reaction to any of the above allergies? _____

Does your child have asthma? Yes No If yes, is it worsened by exercise? Yes No Inhaler required? Yes No

Time interval for repeating dosage: _____

SECTION II – PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT TO COMPLETE

Effective Date: From _____ To _____

The injection will be given immediately after report of exposure with reaction to: _____
Student's Name

Route of exposure (circle): ingestion / skin contact / inhalation / insect sting or bite

Check appropriate box:

- EpiPen
Give the premeasured dose of 0.3 mg epinephrine by auto injection
- EpiPen Jr.
Give the premeasured dose of 0.15 mg epinephrine by auto injection

Antihistamine Brand or Generic: _____

Dose: _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Inject Epinephrine immediately, Call 911, monitor student and give additional antihistamines. -- SEVERE Symptoms:
Pale, blue, dizzy, obstructive swelling, confused, trouble breathing/swallowing, tight or hoarse throat, many hives over the body, vomiting, itchy face/mouth.

Give antihistamine, alert parent, monitor student. – MILD Symptoms:
Few hives, mild nausea, discomfort

PHYSICIAN/AUTHORIZATION SIGNATURE

DATE

PARENT/GUARDIAN AUTHORIZED SIGNATURE

DATE