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SCS ALLERGY ACTION PLAN 2024-2025

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 PRACTIONER/PHYSICIAN ASSISTANT TO COMPLETE

Effective Date: From _____ To _____

The injection will be given immediately after report of exposure with reaction to: _____
cause of reaction

Route of exposure: ☐ ingestion ☐ skin contact ☐ ingestion ☐ 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: _____

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

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

_____
PHYSICIAN/AUTHORIZATION SIGNATURE DATE

_____
PARENT/GUARDIAN AUTHORIZED SIGNATURE DATE