



SCS ALLERGY ACTION PLAN 2026-2027

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: _____
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: _____

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