Food Allergy Action Plan | **2025-2026**

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INSERT IMAGE HERE

Student's Name:_____ D.O.B**:** _____

Catechist:_____

ALLERGY TO:

Asthmatic _____Yes* _____No *Higher risk for severe reaction

STEP 1: TREATMENT
Symptoms: Give Checked Medication :

* If a food allergen has been ingested, but no symptoms:	☐ EpiPen	☐ Antihistamine
* Mouth Itching, tingling, or swelling of lips, tongue, mouth:	☐ EpiPen	☐ Antihistamine
* Skin Hives, itchy rash, swelling of the face or extremities:	☐ EpiPen	☐ Antihistamine
* Gut Nausea, abdominal cramps, vomiting, diarrhea:	☐ EpiPen	☐ Antihistamine
* Throat = Tightening of throat, hoarseness, hacking cough:	☐ EpiPen	☐ Antihistamine
* Lung = Shortness of breath, repetitive coughing, wheezing:	☐ EpiPen	☐ Antihistamine
* Heart = ~~Thready pulse, low blood pressure, fainting, pale, blue~~ness:	☐ EpiPen	☐ Antihistamine
* Other = :	☐ EpiPen	☐ Antihistamine
* If reaction is progressing (several of the above areas affected), give	☐ EpiPen	☐ Antihistamine

The severity of symptoms can quickly change. Potentially life threatening.
DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr.

Antihistamine: ~~give~~ _____ medication/dose/route

Other: give medication/dose/route

STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad: _____) .

State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ at _____

3. Emergency contacts:
Name/Relationship Phone Number(s)
a. _____
1.) _____
2.) _____

b. _____
1.) _____
2.)_____

c. _____
1.) _____
2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

The student is both capable and responsible for self administering the Epi Pen
☐ Yes ☐ NO

I give my permission to have trained persons administer an Epi Pen prescribed by Dr. _____to my child.

TRAINED STAFF MEMBERS
1. _____ Room _____
2. _____ Room _____
3. _____ Room _____

- I give my permission to **Holy Cross**, to share with appropriate personnel this information as deemed necessary for my child's health and safety.
- I release **Holy Cross**, its officers, directors, agents, employees, independent contractors, licensees and assignees from all claims that I now have or in the future may have, relating to the above.
- I am the parent or guardian of the minor(s) named below, and I hereby consent to the foregoing on behalf of the minor(s) and myself.

Parent /Guardian Signature _____ Doctor's Signature _____
Date:_____ Date: _____