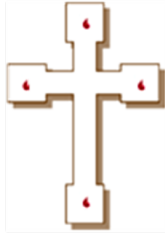
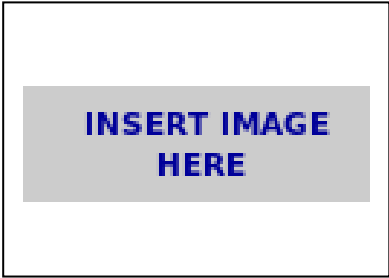


Food Allergy Action Plan | 2026-2027



The Parish of the Holy Cross
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Nesconset, New York 11767
(631) 265-2200
Email: religioused@holycrossrc.org



Mrs. Jennifer Miller
Coordinator, Religious Education Ext. 112

Mrs. Mary Pannone
Secretary of Religious Education Ext. 111

Student's Name: _____

D.O.B: _____

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, blueness: 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

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STEP 2: EMERGENCY CALLS

1. Call 911

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 _____

Date: _____

Doctor's Signature _____

Date: _____