Food Allergy Action Plan | **2023-2024**

The Parish of the Holy Cross
95 Old Nichols Road
Nesconset, New York 11767
(631) 265-2200
email-hcreled@optonline.net

Mrs. Tricia Clarke
Director of Religious Education Ext.112

Mrs. Mary Pannone
Secretary of Religious Education Ext.111

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, 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

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: _____