# LEVITTOWN PUBLIC SCHOOLS

**Levittown Memorial Education Center**
**150 Abbey Lane**
**Levittown, New York 11756**

Success For Every Student

## FOOD ALLERGY ACTION PLAN

Health Services – School Year: _____

Student Name: _____ DOB:_____ Teacher: _____

Allergy to: _____

Asthma ☐ yes* ☐ no *Higher risk for severe reaction

**Symptoms:**

**Give Checked Medication****
****To be determined by physician authorizing treatment**

| | | |
|---|---|---|
| • If a food allergen has been ingested, but no symptoms: | _____Epinephrine | _____Antihistamine |
| • Mouth: Itching, tingling or swelling of lips, tongue, mouth | _____Epinephrine | _____Antihistamine |
| • Skin: Hives, itchy rash, swelling of the face or extremities | _____Epinephrine | _____Antihistamine |
| • Gut: Nausea, abdominal cramps, vomiting, diarrhea | _____Epinephrine | _____Antihistamine |
| • Throat:+ Tightening of throat, hoarseness, hacking cough | _____Epinephrine | _____Antihistamine |
| • Lung:+ Shortness of breath, repetitive coughing, wheezing | _____Epinephrine | _____Antihistamine |
| • Heart:+ Weak or thread pulse, low blood pressure, fainting, pale, blueness | _____Epinephrine | _____Antihistamine |
| • Other:+ _____ | _____ Epinephrine | _____Antihistamine |

+Potentially life-threatening. The severity of symptoms can quickly change.

**DOSAGE:**
Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15mg

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 needed.
2. Doctor: _____ Phone Number: _____
3. Parent: _____ Phone Number(s): _____
4. Emergency contacts:

| Name/Relationship | Phone Number(s) | |
|---|---|---|
| a. _____ | 1. _____ | 2. _____ |
| b. _____ | 1. _____ | 2._____ |

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

Parent/Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____