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: _____