GWISD

# George West Independent School District

## EPI / Allergy Action Plan School Year _____

**ALLERGIC TO:**_____

Name of Student: _____ DOB: _____ Grade/Teacher: _____

Bus #: _____ Bus Driver: AM: _____ PM: _____

Asthmatic _____Yes* _____ No *High risk for severe reaction

_____ Requires an inhaler at school and Asthma Action Plan.

### ◆ SIGNS OF AN ALLERGIC REACTION ◆

| **Systems:** | **Symptoms: (circle appropriate symptoms)** |
|---|---|
| **-MOUTH** | itching, tingling, and swelling of the lips, tongue, or mouth |
| **-THROAT*** | tightness of throat, hoarseness, and hacking cough |
| **-SKIN** | hives, itchy rash, and/or swelling about the face or extremities |
| **-GUT** | nausea, abdominal cramps, vomiting, and/or diarrhea |
| **-LUNG*** | shortness of breath, repetitive coughing, wheezing |
| **-HEART*** | weak or thready pulse, low blood pressure, fainting, pale, blueness |
| **-OTHER** | _____ |

**The severity of symptoms can quickly change and potentially progress to a life-threatening situation.**

### ◆ ACTION FOR MINOR REACTION ◆

If **symptom(s)** are mild: □ **Benadryl** _____
(dosage)

Other Medicine List: _____
(medication/dosage/route)

If condition does not improve within 10 minutes or worsens any time, follow steps for Major Reaction below.

### ◆ ACTION FOR MAJOR REACTION ◆

If ingestion is suspected and/or symptoms are major give the following **IMMEDIATELY!**

□ **Epinephrine (Epi-Pen) 0.15mg Jr** □ **Epinephrine (Epi-Pen) 0.3 mg**

**CALL 911 AND THE PARENT/GUARDIAN.**

**Physician's Signature _____ Date: _____**
**Print/Stamp physician name, address and phone number:**



**913 Houston Street, George West, TX 78022 361-449-1914 fax 361-449-1426 www.gwisd.esc2.net**

# George West Independent School District

## Allergy Action Plan (con't)

Name of Student: _____ DOB: _____

School: _____ Grade/Teacher: _____

**All medication for use at school will be furnished by parent or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).**

**Parent Permission**

I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication. This consent is good for one year, unless revoked.
I give permission to the school nurse and other designated staff members of George West ISD to perform and carry out the tasks as outlined by this Allergy Action Plan. I also consent to the release of the information contained in this Allergy Action Plan to all staff members and other adults who have custodial care of my child and who need to know this information in order to maintain my child's health and safety. I am aware that it is my responsibility to update the school if my contact information were to change.

**Acknowledged and received by:**

Parent/Guardian _____ Date _____

Parent Email address _____ Parent Phone Numbers _____

**EMERGENCY CONTACTS:** Name/Relation

1._____a) home_____ b) work _____ c) cell_____

2._____a) home_____ b) work _____ c) cell_____

3._____a) home_____ b) work _____ c) cell_____

Principal's Signature _____ Date _____

School Nurse's Signature _____ Date _____