

Report of Epinephrine Administration

Student Demographics and Health History

1. School District: _____ Name of School: _____
2. Age: _____ Type of Person: Student Staff Visitor Gender: M F Ethnicity: Spanish/Hispanic/Latino: Yes No
3. Race: American Indian/Alaskan Native African American Asian Native Hawaiian/other Pacific Islander White Other
4. History of severe or life-threatening allergy: Yes, Known by student/family Yes, Known by school Unknown
 If known, specify type of allergy: _____
- If yes, was allergy action plan available at school? Yes No Unknown
- History of anaphylaxis: Yes, Known by student/family Yes, Known by school Unknown
- Previous epinephrine use: Yes, by student/family Yes, at school No Unknown
- Diagnosis/History of asthma: Yes, Known by student/family Yes, known by school No Unknown

School Plans and Medical Orders

5. Individual Health Care Plan (IHCP) in place? Yes No Unknown
6. Written school district policy on management of life-threatening allergies in place? Yes No Unknown
7. Does the student have a student specific order for epinephrine? Yes No Unknown
8. Expiration date of epinephrine _____ Unknown

Epinephrine Administration Incident Reporting

9. Date/Time of occurrence: _____ Vital signs: BP _____/____ Temp _____ Pulse _____ Respiration _____
10. If known, specify trigger that precipitated this allergic episode:
 Food Insect Sting Exercise Medication Latex Other _____ Unknown
- If food was a trigger, please specify which food _____
 Please check: Ingested Touched Inhaled Other specify _____
11. Did reaction begin prior to school? Yes No Unknown
12. Location where symptoms developed:
 Classroom Cafeteria Health Office Playground Bus Other specify _____
13. How did exposure occur?

14. Symptoms: (Check all that apply)
- | <u>Respiratory</u> | <u>GI</u> | <u>Skin</u> | <u>Cardiac/Vascular</u> | <u>Other</u> |
|--|--|---|---|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Abdominal discomfort | <input type="checkbox"/> Angioedema | <input type="checkbox"/> Chest discomfort | <input type="checkbox"/> Diaphoresis |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Flushing | <input type="checkbox"/> Cyanosis | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Hoarse voice | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> General pruritis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Nasal congestion/rhinorrhea | <input type="checkbox"/> Oral Pruritis | <input type="checkbox"/> General rash | <input type="checkbox"/> Faint/Weak pulse | <input type="checkbox"/> Metallic taste |
| <input type="checkbox"/> Swollen (throat, tongue) | <input type="checkbox"/> Nausea | <input type="checkbox"/> Hives | <input type="checkbox"/> Headache | <input type="checkbox"/> Red eyes |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Lip swelling | <input type="checkbox"/> Hypotension | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Stridor | | <input type="checkbox"/> Localized rash | <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Uterine cramping |
| <input type="checkbox"/> Tightness (chest, throat) | | <input type="checkbox"/> Pale | | |
| <input type="checkbox"/> Wheezing | | | | |

15. Location where epinephrine administered: Health Office Other specify _____

16. Location of epinephrine storage: Health Office Other specify _____

17. Epinephrine administered by: RN Self Other

If epinephrine was self-administered by a student at school or a school-sponsored function, was the student formally trained?
 Yes If known, date of training _____ No
 Did the student follow school protocols to notify school personnel and activate EMS? Yes No NA

If epinephrine was administered by other, please specify _____
 Was this person formally trained? Yes Date of training _____ No Don't know

18. Time elapsed between onset of symptoms and communication of symptoms: _____ minutes

19. Time elapsed between communication of symptoms and administration of epinephrine: _____ minutes
 Parent notified of epinephrine administration: (time) _____

20. Was a second dose of epinephrine required? Yes No Unknown
 If yes, was that dose administered at the school prior to arrival of EMS? Yes No Unknown
 Approximate time between the first and second dose _____
 Biphasic reaction: Yes No Unknown

Disposition

21. EMS notified at: (time) _____
 Transferred to ER: Yes No Unknown
 If yes, transferred via ambulance Parent/Guardian Other Discharged after _____ hours
 Parent: At school Will come to school Will meet student at hospital Other: _____

22. Hospitalized: Yes If yes, discharged after _____ days No Name of hospital: _____

23. Student/Staff/Visitor outcome: _____

If first occurrence of allergic reaction:

a. Was the individual prescribed an epinephrine auto injector in the ER? Yes No Don't know

b. If yes, who provided the epinephrine auto injector training?
 ER PCP School Nurse Other _____ Don't know

c. Did the ER refer the individual to PCP and/or allergist for follow-up? Yes No Don't know

School Follow-up

24. Did a debriefing meeting occur? Yes No Did family notify prescribing MD? Yes No Unknown

25. Recommendation for changes: Protocol change Policy change Educational change Information sharing None

26. Comments (include names of school staff, parent, others who attend debriefing): _____

27. Form completed by: _____ Date: _____
(Please Print)

Title: _____

Phone number: (_____) _____ - _____ Ext.: _____ Email : _____

School District: _____

School address: _____