Sample Report

This template may be used by the school division to develop a reporting form for the use of epinephrine.

Report of Epinephrine Administration

Demographics and Health History

School District: _____ **School Name:** _____

Type of Person: ☐ Student ☐ Staff ☐ Visitor **Gender:** ☐ M ☐ F ☐ Non-binary

Race: ☐ American Indian/Alaskan Native ☐ African American ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ White ☐ Other: _____

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

Individual Health Care Plan (IHP) in place?	☐ Yes	☐ No	☐ Unknown
Written school district policy on management of life-threatening allergies in place?	☐ Yes	☐ No	☐ Unknown
Does the student have a student specific order for epinephrine?	☐ Yes	☐ No	☐ Unknown
	☐ Unknown		

Expiration Date of epinephrine: ____/____/____

Epinephrine Administration Incident Reporting

Date/Time of Occurrence: _____/_____/_____ _____:_____ ○ ○ am/pm

Vital Signs: BP ____/____ Temp _____ Pulse _____ Respiration_____

If known, specify trigger that precipitated this allergic episode: ☐ Insect sting ☐ Medication ☐ Food ☐ Exercise ☐ Latex ☐ Unknown ☐ Other: _____

If food was a trigger, please specify which food: _____ ☐ Ingested ☐ Touched ☐ Inhaled

Did reaction begin prior to school? ○ Yes ○ No ○ Unknown

Sample Report

Location where symptoms developed:

☐Classroom ☐Cafeteria ☐Health Office/Clinic ☐Playground ☐Bus ☐Other
If other, specify: _____

How did exposure occur? _____

_____

Symptoms: (Check all that apply.)

Respiratory	GI	Skin	Cardiac/Vascular	Other
☐ Cough	☐ Abdominal discomfort	☐ Angioedema	☐ Chest discomfort	☐ Diaphoresis
☐ Difficulty breathing	☐ Diarrhea	☐ Flushing	☐ Cyanosis	☐ Irritability
☐ Hoarse voice	☐ Difficulty swallowing	☐ General pruritus	☐ Dizziness	☐ Loss of consciousness
☐ Nasal congestion/rhinorrhea	☐ Oral pruritus	☐ General rash	☐ Faint/weak pulse	☐ Metallic taste
☐ Swollen throat/tongue	☐ Nausea	☐ Hives	☐ Headache	☐ Red eyes
☐ Shortness of breath	☐ Vomiting	☐ Lip swelling	☐ Hypotension	☐ Sneezing
☐ Stridor		☐ Localized rash	☐ Tachycardia	☐ Uterine cramping
☐ Tightness (chest, throat)		☐ Pale		
☐ Wheezing				

Location epinephrine was administered: ☐Health Office/Clinic ☐Other Specify:_____

Location of epinephrine storage: ☐Health Office/Clinic ☐Other Specify:_____

Epinephrine administered by: ☐School Nurse ☐Teacher ☐Self ☐Other/Specify:_____

If epinephrine was administered by other, was the person formally trained?
☐Yes If known, date of training: ____/____/____ ☐No ☐Unknown

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

TIME ELAPSED

- **between onset of symptoms and communication of symptoms:** _____minutes
- **between communication of symptoms and administration of epinephrine:** _____minutes

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: _____ minutes
Biphasic reaction? ◯Yes ◯No ◯ Unknown

Disposition

EMS notified at (time): _____:_____ ◯ ◯ am/pm **Transferred to ER:** ◯Yes ◯ No
If yes, transferred via ☐Ambulance ☐Parent/guardian ☐Other **Discharged after _____hours**

Hospitalized? ☐No ☐Yes ☐ If yes, discharged after _____day(s) **Name of hospital:**_____

Student/Staff/Visitor outcome: _____
_____

Sample Report

If first occurrence of allergic reaction:

- Was the individual prescribed an epinephrine autoinjector in the ER? ◯Yes ◯No ◯ Unknown
- If yes, who provided the epinephrine autoinjector training? ◯Yes ◯No ◯ Unknown
- Did the ER refer the individual to PCP and/or allergist for follow-up? ◯Yes ◯No ◯ Unknown

Parental Notification

When was the parent/guardian notified of epinephrine administration (time)? _____:_____◉ ◯am/pm
Parent/guardian: ☐Will come to school ☐Will meet student at hospital ☐Currently at school
☐Other:_____

School Follow-Up

Did a debriefing meeting occur? ◯ Yes ◯ No ◯ Unknown

Notify prescribing MD? ◯ Yes ◯ No ◯ Unknown **Notify LHD?** ◯ Yes ◯ No ◯ Unknown

Recommendations for changes?

☐Protocol/Policy ☐Training ☐Education ☐Information sharing
☐Other: _____

Optional **Student Information**

Name: _____

Date of Birth: _____/_____/_____ **Grade: _____** **Age: _____**

Contact Information

Please provide contact information of the individual who completed this form.

Name: _____

Role: _____

Email address: _____

Phone Number: (_____) - _____ - _____

Date: _____/_____/_____

The School Nurse will need to complete all pages of this form within three (3) calendar days after the administration of any undesignated stock epinephrine.

Revised and used with permission of the Massachusetts Department of Health, School Health Unit.