*Report of Anaphylactic Reaction/ Epinephrine Administration: Revised and used with permission of the Massachusetts Department of Health, School Health Unit*

**Demographics and Health History: Circle or fill in the response**

1. **School District: Name of School:**

**School Type:** ES EM EMH M MH HS

1. **Person receiving EPI Pen injection:** Student Faculty Staff Parent/Volunteer Other

Age: Gender: M F Ethnicity: Spanish/Hispanic/Latino: Yes No

1. **Race:** American Indian/Alaskan Native Black or African American Native Hawaiian/Other Pacific Islander White Two or More Races
2. **History of Allergy:** Yes No Unknown

**If known, Type of Allergy:** Insect Bite/Sting Egg Apple Pineapple Strawberry Kiwi Other Fruit Peanut Soy Fish Shellfish Vegetable Wheat Medication Tree nuts Dairy (Cow’s milk) Sesame Other

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **If yes, was allergy action****plan available?** | Yes | No | Unknown | **History of anaphylaxis:** | Yes | No | Unknown |
| **Previous epinephrine use:** | Yes | No | Unknown | **Diagnosis/History of asthma:** | Yes | No | Unknown |

1. **Does student have and individual Health Plan(IHP)/Emergency Plan (EP) in place?** Yes No Unknown
2. **Does the student have a student specific order for epinephrine?** Yes No Unknown

**Epinephrine Administration Incident Reporting**

1. **Date/ Time of occurrence Vital Signs: BP** / **Temp Pulse Respiration**
2. **If known, specific trigger(s)/Exposure that precipitated or may have precipitated this allergic episode:**

Food Insect Bite/Sting Exercise Medication Latex Unknown Other

If food was the trigger, specify which food:

Packaged, labelled food Multi-ingredient food Food provided by another individual/shared food Exposure to known allergen Unknown Other

**Please circle regarding food trigger:** Ingested Touched Inhaled Unknown Other

1. **Did reaction begin prior to school?** Yes No Unknown
2. **Location where symptoms developed:**

Health Office Cafeteria Classroom Playground/school grounds Gymnasium Auditorium Athletic Field Bus Field Trip/Off Site Work Site/Office Other

1. **How did exposure occur?**
2. **Symptoms: (Circle all that apply)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Respiratory** | **GI** | **Skin** | **Cardiac/Vascular** | **Other** |
| Cough | Abdominal discomfort | Localized swelling | Chest discomfort |  |
| Difficulty breathing | Diarrhea | Flushing | Cyanosis | Irritability |
| Hoarse voice | Difficulty swallowing | General itching | Dizziness | Metallic taste |
| Nasal congestion/runny nose | Oral itching | General rash | Faint/Weak pulse | Red eyes |
| Swollen (throat, tongue) | Nausea | Hives | Hypotension | Uterine cramping |
| Shortness of Breath | Vomiting | Localized Rash | Tachycardia | Headache |
| Stridor |  | Lip swelling | (rapid heart rate) |  |
| Tightness (chest, throat) WheezingSneezing |  | Pale Profuse Sweating | PaleLoss of consciousness |  |

1. **Location where Epinephrine Administered:**

Health Office Cafeteria Classroom Playground/school grounds Gymnasium Auditorium Athletic Field Bus Field Trip/Off Site Work Site/Office Other

1. **Source of Epinephrine/Storage:**

Stock Epinephrine (Health Office or Nurses Office) Self Carry/Self Provided (per medication order)

Nurses Emergency Bag Athletic Trainer Office/Gymnasium Office Parent/Guardian Provided (per medication order) Other

1. **Epinephrine Administered by:**

RN LPN Self Athletic Trainer/Coach Teacher/Principal School Health Aid/Technician Other School Employee Other

**Time Epinephrine administered** \_ **Dose of Epinephrine:** 0.15 mg 0.30 mg Other

1. **Brand of Epinephrine Administered:**

EpiPen/EpiPen Jr AuviQ AdrenaClick Impax Epinephrine Epinephrine Injection, USP Generic Unknown Other

1. **Parent/Guardian notified of Epinephrine administration:** Yes No

Time of Notification Notified By whom

1. **Was a second dose of auto injectable epinephrine required due to a biphasic reaction (i.e. reoccurring/ worsening of anaphylactic symptoms)?** Yes No Unknown

If yes, was the dose administered at the school prior to the Emergency Medical Systems (EMS) arrival?

Yes No Unknown

Approximate Time between first and second dose

**Disposition**

1. **Disposition (description optional):**
2. **EMS Notified at:** Time By whom:
3. **Transferred to hospital emergency department?** Yes No
4. **If No, why not transferred?**

EMS Recommendation or refusal Parent/Guardian refused Other

1. **If yes, Transferred via:** Ambulance Parent/Guardian Other
2. **Condition on ED transport:**

Asymptomatic (no symptoms) Mild Symptoms Airway or Cardiovascular symptoms Unconscious on Transfer Deceased

**School Follow-up**

1. **Were parents/guardians advised to follow up with students’ Primary Care Provider (PCP)?** Yes No
2. **Were arrangements made to restock auto injectable epinephrine?** Yes No

## Notes:

**Form Completion and Signatures**

Form completed by (Print Name):

Signature:

Phone Number:

School Address:

## Submission

*Upon electronic submission of the information on this form, the data will be sent to: Maryland State Department of Education, School Health Services Section. If you have questions please contact: Alicia Mezu, MSN/Ed, BSN,RN Email:* *alicia.mezu@maryland.gov* *or Fax: (410) 333-0880. Thank you!*