MARYLAND STATE DEPARTMENT OF EDUCATION
EQUITY AND EXCELLENCE

Maryland State Department of Education (MSDE)- School Health Services Form

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

2. Person receiving EPI Pen injection: Student Faculty Staff Parent/Volunteer Other __________________

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

3. Race: American Indian/Alaskan Native Black or African American Native Hawaiian/Other Pacific Islander White Two or More Races

4. 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

5. Does student have and individual Health Plan(IHP)/Emergency Plan (EP) in place? Yes No Unknown

6. Does the student have a student specific order for epinephrine? Yes No Unknown

Epinephrine Administration Incident Reporting

7. Date/ Time of occurrence ______________ **Vital Signs: BP**___/____ **Temp** ______ **Pulse**_____ **Respiration** ______

8. 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________________

9. Did reaction begin prior to school? Yes No Unknown

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10. Location where symptoms developed:

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

11. How did exposure occur?

12. 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)		Pale	Pale	
Wheezing		Profuse Sweating	Loss of consciousness	
Sneezing				

13. Location where Epinephrine Administered:

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

14. 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

15. 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

16. Brand of Epinephrine Administered:

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

17. Parent/Guardian notified of Epinephrine administration: Yes No

Time of Notification___________ **Notified By whom**______________________________________

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18. 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

19. Disposition (description optional): ____

20. EMS Notified at: Time__________________ By whom: ____

21. Transferred to hospital emergency department? Yes No

22. If No, why not transferred?

EMS Recommendation or refusal Parent/Guardian refused Other

23. If yes, Transferred via: Ambulance Parent/Guardian Other

24. Condition on ED transport:

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

School Follow-up

25. Were parents/guardians advised to follow up with students' Primary Care Provider (PCP)? Yes No

26. Were arrangements made to restock auto injectable epinephrine? Yes No

27. 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!