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)

<table>
<thead>
<tr>
<th>Respiratory</th>
<th>GI</th>
<th>Skin</th>
<th>Cardiac/Vascular</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cough</td>
<td>Abdominal discomfort</td>
<td>Localized swelling</td>
<td>Chest discomfort</td>
<td>Irritability</td>
</tr>
<tr>
<td>Difficulty breathing</td>
<td>Diarrhea</td>
<td>Flushing</td>
<td>Cyanosis</td>
<td>Metallic taste</td>
</tr>
<tr>
<td>Hoarse voice</td>
<td>Difficulty swallowing</td>
<td>General itching</td>
<td>Dizziness</td>
<td>Red eyes</td>
</tr>
<tr>
<td>Nasal congestion/runny nose</td>
<td>Oral itching</td>
<td>General rash</td>
<td>Fainting/Weak pulse</td>
<td>Uterine cramping</td>
</tr>
<tr>
<td>Swollen (throat, tongue)</td>
<td>Nausea</td>
<td>Hives</td>
<td>Hypotension</td>
<td></td>
</tr>
<tr>
<td>Shortness of Breath</td>
<td>Vomiting</td>
<td>Localized Rash</td>
<td>Tachycardia (rapid heart rate)</td>
<td></td>
</tr>
<tr>
<td>Stridor</td>
<td></td>
<td>Lip swelling</td>
<td>Pale</td>
<td></td>
</tr>
<tr>
<td>Tightness (chest, throat)</td>
<td></td>
<td>Pale</td>
<td>Loss of consciousness</td>
<td></td>
</tr>
<tr>
<td>Wheezing</td>
<td></td>
<td>Profuse Sweating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sneezing</td>
<td></td>
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</tr>
</tbody>
</table>

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. reoccuring/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 __________________________________________

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

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!