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

Report of Anaphylactic Reaction/Epinephrine Administration

Demographics and Health History

1. School District: _____ Name of School: _____

2. Type of Person: ☐ Student ☐ Other Age:_____ Gender: M ☐ F ☐ Ethnicity: Spanish/Hispanic/Latino: ☐ Yes ☐ No

3. Race/Ethnicity: ☐ American Indian/Alaskan Native ☐ African American ☐ Asian ☐ Native Hawaiian/other Pacific Islander ☐ White ☐ Other

4. History of allergy: ☐ Yes ☐ No ☐ Unknown If known, specify type of allergy: _____

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

School Plans and Medical Orders

5. Does student have an 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, specify trigger(s)/exposure that precipitated or may have precipitated this allergic episode:

☐ Food ☐ Insect Sting ☐ Exercise ☐ Medication ☐ Latex ☐ Other (specify) _____ ☐ Unknown

If food was a trigger, please specify which food _____

Please check: ☐ Ingested ☐ Touched ☐ Inhaled ☐ Other (specify) _____

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

10. Location where symptoms developed:

☐ Classroom ☐ Cafeteria ☐ Health Office ☐ Playground ☐ Bus ☐ Other (specify) _____

11. How did exposure occur?

_____

_____

12. Symptoms: (Check all that apply)

Respiratory	**GI**	**Skin**	**Cardiac/Vascular**	**Other**
☐ Cough	☐ Abdominal discomfort	☐ Localized swelling	☐ Chest discomfort	☐ Profuse sweating
☐ Difficulty breathing	☐ Diarrhea	☐ Flushing	☐ Cyanosis	☐ Irritability
☐ Hoarse voice	☐ Difficulty swallowing	☐ General itching	☐ Dizziness	☐ Loss of consciousness
☐ Nasal congestion/runny nose	☐ Oral itching	☐ 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 (rapid heart rate)	☐ Uterine cramping
☐ Tightness (chest, throat)		☐ Pale		
☐ Wheezing				

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13. Location where epinephrine administered: ☐ Health Office ☐ Other (specify) _____

14. Location of epinephrine storage: ☐ Health Office ☐ Other (specify) _____

15. Epinephrine administered by: ☐ RN ☐ LPN ☐ Self ☐ Other (specify) _____ Time: _____

Dose of epinephrine administered: ☐ 0.15 mg ☐ 0.30 mg ☐ Other (specify) _____

16. Parent/guardian notified of epinephrine administration: ☐ Yes ☐ No Time: _____

By whom: _____

17. 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 Emergency Medical Systems (EMS) arrival? ☐ Yes ☐ No ☐ Unknown

Approximate time between the first and second dose _____

Disposition

18. EMS notified at: (time) _____ By whom: _____

Transferred to hospital emergency department: ☐ Yes ☐ No If "No," provide reason: _____

If yes, transferred via ☐ Ambulance ☐ Parent/Guardian ☐ Other

19. Outcome: _____

School Follow-up

20. Were parents/guardians advised to follow up with student's primary care provider? ☐ Yes ☐ No

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

22. Notes: _____

_____

_____

23. Form completed by: _____ Date: _____
(Please print)

Signature: _____ Title: _____

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

School address: _____

Submit completed form to:
Maryland State Department of Education, School Health Services Section
Attention: Alicia Mezu, MSN/Ed, BSN, RN
Email: alicia.mezu@maryland.gov or Fax: (410) 333-8148