

**School Health Unit
Massachusetts Department of Public Health**

Report of Epinephrine Administration (2010-2011)

Please mail 2 page form to: MDPH, School Health Unit, 250 Washington St., 5th Floor, Boston, MA 02108-4619 or (Fax 617.624.6062)

1 School District: _____ Name of School: _____

2 Age: _____ Type of Person: Student Staff Visitor Gender: M F Ethnicity: Spanish/Hispanic/Latino: Yes No

3 Race: 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 Don't Know History of anaphylaxis: Yes No Unknown

Previous epinephrine use: Yes No Don't Know Diagnosis/History of asthma: Yes No Don't Know

5 Date/Time of occurrence: _____ Vital signs: BP _____/____ Temp _____ Pulse _____ Respiration _____

6 If known, specify trigger that precipitated this allergic episode:

Food Insect Sting Exercise Medication Latex Other _____ Unknown

If food was a trigger, please specify which food _____

Please check: Ingested Touched Inhaled Other specify _____

7. Did reaction begin prior to school? Yes No Don't Know

8. Location where symptoms developed:

Classroom Cafeteria Health Office Playground Bus Other specify _____

9. How did exposure occur?

10. Symptoms: (Check all that apply)

Respiratory

- Cough
- Difficulty breathing
- Hoarse voice
- Nasal congestion/rhinorrhea
- Swollen (throat, tongue)
- Shortness of Breath
- Stridor
- Tightness (chest, throat)
- Wheezing

GI

- Abdominal discomfort
- Diarrhea
- Difficulty swallowing
- Oral Pruritis
- Nausea
- Vomiting

Skin

- Angioedema
- Flushing
- General pruritis
- General rash
- Hives
- Lip swelling
- Localized rash
- Pale

Cardiac/Vascular

- Chest discomfort
- Cyanosis
- Dizziness
- Faint/Weak pulse
- Headache
- Hypotension
- Tachycardia

Other

- Diaphoresis
- Irritability
- Loss of consciousness
- Metallic taste
- Red eyes
- Sneezing
- Uterine cramping

11 Location where epinephrine administered: Health Office Other specify _____

12 Location of epinephrine storage: Health Office Other specify _____

13 Epinephrine administered by: RN Self Other

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

Did the student follow school protocols to notify school personnel and activate EMS? Yes No NA

If epinephrine was administered by other, please specify _____

Was this person formally trained? Yes Date of training _____ No Don't know

Expiration date of epinephrine _____ Don't Know

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14 Time elapsed between onset of symptoms and communication of symptoms: _____minutes

15 Time elapsed between communication of symptoms and administration of epinephrine: _____minutes

16 Individual Health Care Plan (IHCP) in place? Yes No Don't know

17 Written school district policy on management of life-threatening allergies in place? Yes No Don't know

18 School district/school registered with MDPH for epinephrine training? Yes No Don't know

Disposition:

19 Transferred to ER: Yes No Don't know

If yes, transferred via ambulance Parent/Guardian Other Discharged after _____ hours

Was a second epi-pen dose required? Yes No Don't know

If yes, was that dose administered at the school prior to arrival of EMS? Yes No Don't know

Approximate time between the first and second dose _____

Biphasic reaction: Yes No Don't know

20 Hospitalized: Yes If yes, discharged after _____ days No

21 Student/Staff/Visitor outcome: _____

If first occurrence of allergic reaction:

a. Was the individual prescribed an Epi Pen in the ER? Yes No Don't know

b. If yes, who provided Epi Pen training? ER PCP School Nurse Other _____ Don't know

c. Did the ER refer the individual to PCP and/or allergist for follow-up? Yes No Don't know

School Follow-up:

22 Did a debriefing meeting occur? Yes No Did family notify prescribing MD? Yes No Don't know

23 Recommendation for changes: Protocol change Policy change Educational change Information sharing None

24 Comments:

25 Form completed by: _____ Date: _____
(please print)

Title: _____

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

School District: _____

School address: _____