5141.21 Form 8

Connecticut Statewide School Health Services Report

Report of Epinephrine* Administration

Please mail or fax form to: Stephanie Knutson, Connecticut State Department of Education, 25 Industrial Park Road, Middletown, CT 06457

Fax number: (860) 807-2127

School District: _____ Name of School: _____ Public [ ] Non Public [ ]

Student/Staff DOB: _____ Gender: M [ ] F [ ] Ethnicity: Spanish/Hispanic/Latino:Yes [ ] No [ ]

Race: American Indian/Alaskan Native [ ] African American [ ] Asian [ ] Native Hawaiian/other Pacific Islander [ ] White [ ]

Diagnosis/History of Asthma: Yes [ ] No [ ] History of Anaphylaxis: Yes [ ] No [ ] Previous Epinephrine Use: Yes [ ] No [ ]

Incident:

Date/Time of occurrence: _____ Known allergen(s): _____

Trigger that precipitated this allergic episode:
_____

Symptoms:
_____

Location of individual when symptoms developed:
_____

Location of individual when Epinephrine administered:
_____

Location of Epinephrine storage:
_____

Epinephrine administered by: RN [ ] Other [ ] If other, please specify:
_____

If other than an RN, was this person formally trained? Yes [ ] No [ ] Date of training: _____

If epinephrine was self-administered by an individual at school or a school-sponsored function, did the individual follow school protocols to notify school personnel and activate EMS?

Yes [ ] No [ ] NA [ ]

Approximate time between onset of symptoms and administration of Epinephrine: _____

Was Epinephrine administered under a patient specific order for a particular student? Yes [ ] No [ ]

Does school district have non-patient specific standing orders/protocols in place for Anaphylaxis? Yes [ ] No [ ]

Individual Health Care Plan (IHCP) in place? Yes [ ] No [ ]

School Physician notified? Yes [ ] No [ ]

Written school district policy on management of life-threatening allergies in place? Yes [ ] No [ ]

Disposition:

Transferred to ER: Yes [ ] No [ ] Discharged after _____ hours

Biphasic reaction: Yes [ ] No [ ] Unknown [ ]

Hospitalized: Yes [ ] No [ ] Discharged after _____ days

Outcome:

Recommendations for changes/improvements to current policy or procedures: Debriefing meeting? Yes [ ] No [ ]

Form completed by: _____ Date: _____

(please print)

Title: _____ Phone number: _____

Address: _____

**EpiPen®, or EpiPen® Jr. or Twinject*