# Severe Allergic Reaction and/or Epinephrine Administration Report

# CDE School Health Services Office | 2024-2025

## CHEAT SHEET

If desired, you can use this form to collect information before submitting the report through [Formsite](https://fs24.formsite.com/305medicaid/form5/index.html).

Do NOT send this form to CDE.

1 CCR 301-68 6.00 Reporting Requirements 6.01: Schools must submit a report to the State School Nurse Consultant at the Department of Education within 10 days regarding **any incident at the school or a school-related event** involving a severe allergic reaction, the administration of an epinephrine auto-injector, **or both**.

| **Question** | **Description** | **Your answer** |
| --- | --- | --- |
| School District/ or Charter/ or BOCES | Use full name of district or organization |  |
| Name of School |  |  |
| Date and Time of Occurrence  | Date: **00/00/00** Time: **0:00 am/pm** |  |
| Age of person who experiencedsevere allergic reaction | Use numbers and decimals only  |  |
| The person who experiencedsevere allergic reaction was a:  | **Student/Non-student** |  |
| Does the person havea known allergy? | **Yes/No/Don’t Know**  |  |
| Was an allergy action plan available? | **Yes/No** |  |
| Diagnosis or History of Asthma? | **Yes/No /Don’t Know**  |  |
| If known, specify trigger that precipitated this allergic episode.  | **Food, Insect sting, Exercise, Medication, Latex, Inhaled, Unknown, Other**If response was OTHER, please explain |  |
| If food was a trigger, please specify which food.  | **Tree Nut, Peanut, Wheat, Dairy, Fish, Eggs, Shellfish, Soy, Sesame, Other**If response was OTHER, please explain |  |
| Location where symptoms developed.  | **Off school grounds, Classroom, Cafeteria, Health Office, Playground, Bus, Other** If response was OTHER, please explain*.* |  |
| How was the incident triggered? | **Ingested, Touched, Inhaled, Other**  If response was OTHER, please explain*.* |  |
| Symptoms:Respiratory Symptoms (check all that apply) | * **Cough**
* **Difficulty breathing**
* **Hoarse voice**
* **Nasal congestion/runny nose**
* **Swollen throat/and or tongue**
* **Shortness of breath**
* **Itching - mouth/throat**
* **Tightness - chest/throat**
* **Wheezing**
* **Does not apply**
 |  |
| GI Symptoms (check all that apply) | * **Abdominal discomfort**
* **Diarrhea**
* **Difficulty swallowing**
* **Nausea**
* **Vomiting**
* **Does not apply**
 |  |
| Skin Symptoms (check all that apply) | * **Flushing**
* **General itching**
* **General rash**
* **Hives**
* **Lip Swelling**
* **Localized rash**
* **Pale**
* **Does not apply**
 |  |
| Cardiovascular Symptoms (check all that apply) | * **Chest discomfort**
* **Bluish skin**
* **Dizziness**
* **Weak pulse**
* **Headache**
* **Heart racing**
* **Does not apply**
 |  |
| Other Symptoms(check all that apply) | * **Sweating**
* **Irritability**
* **Loss of consciousness**
* **Metallic taste**
* **Red eyes**
* **Sneezing**
* **Does not apply**
 |  |
| Does your school have stock epinephrine?  | **Yes/No** |  |
| Auto-injector used (choose one) | **Students/Stock Epi-Pen/ N/A epinephrine not administered** |  |
| Epinephrine administered by:  | **N/A, RN, School Staff, EMS, Parent, Self (Student), Other** If response was OTHER, please explain |  |
| Location where epinephrine was administered.  | **N/A, Health Office, Classroom, Ambulance, Front/Main Office, Other** If response was OTHER, please explain |  |
| Location of epinephrine storagePlease choose one from the following drop down menu.   | **N/A, Classroom, Student Self-Carries, Health Office, Other** |  |
| DISPOSITION:Transferred to ER? | **Yes/No/Don’t Know**  |  |
| If transferred, how? Please chose one:  | **Ambulance, Parent/Guardian/Other** If response was OTHER, please explain |  |
| Was a second epi-pen dose required? | **Yes, No, N/A, Don’t Know** |  |
| If response was yes, was that dose administered at the school prior to arrival of EMS? | **Yes/No/Don’t Know** |  |
| Time elapsed between communication ofsymptoms and administration of epinephrine | **HOURS\_\_\_\_\_\_\_ MINUTES\_\_\_\_\_\_\_** |  |
| Form Completed BY:  |  |  |
| First Name |  |  |
| Last Name |  |  |
| Title  |  |  |
| Phone Number |  |  |
| Date Form Completed  | **Date: 00/00/00** |  |
| E-mail Address |  |  |