

## Report of Stock Epinephrine Administration

Please email or mail form to: Iowa Department of Education School Nurse Consultant

Email: [melissa.walker@iowa.gov](mailto:melissa.walker@iowa.gov)

Mail: School Nurse Consultant, 400 East 14<sup>th</sup> Street, Des Moines, Iowa 50319-0146

1. School District: \_\_\_\_\_ Name of School: \_\_\_\_\_
2. Age: \_\_\_\_\_ Type of Person: Student  Staff  Visitor  Gender: M  F
3. Diagnosis/history of asthma: Yes  No  Diagnosis/history of anaphylaxis: Yes  No
4. Date/Time of occurrence: \_\_\_\_\_ Known allergen(s): \_\_\_\_\_
5. Trigger that precipitated the allergic episode: \_\_\_\_\_
6. Symptoms: \_\_\_\_\_
7. Location of student when symptoms developed: Classroom  Cafeteria  Health Office  Playground   
Other  - specify: \_\_\_\_\_
8. Location of student when epinephrine administered: Health Office  Other -specify \_\_\_\_\_
9. Location of epinephrine storage: Health Office  Other -specify +: \_\_\_\_\_
10. Epinephrine administered by: School Nurse (RN)  Other   
If other, please specify \_\_\_\_\_  
Was the person formally trained? Yes  No  Date of training \_\_\_\_\_
11. If epinephrine was self-administered by a student at school or a school-sponsored function, did the student follow school protocols and was EMS activated? Yes  No  NA
12. Approximate time between onset of symptoms and administration of epinephrine: \_\_\_\_\_ minutes
13. Individual Health or Emergency Plan in place for the student, if there was a diagnosis of anaphylaxis? Yes  No   
If yes, was the student's healthcare provider notified? Yes  No   
If yes, was there a prescription for an epinephrine injector available at the school: Yes \_\_\_\_ No \_\_\_\_  
If yes, please explain the reason for not administering the student's prescribed medication:  
\_\_\_\_\_
14. Is there a district protocol for management of life-threatening allergies in place? Yes  No

### Student or Individual Disposition:

15. Transferred to ER: Yes  No  Biphasic reaction (was a second dose administered): Yes  No  Unknown
16. Hospitalized: Yes  No
17. Student/Staff/Visitor Outcome: \_\_\_\_\_
18. Did a debriefing meeting occur? Yes  No  Medication Error Occur: Yes \_\_\_\_ No \_\_\_\_ Medication Incident Occur: Yes \_\_\_\_ No \_\_\_\_
19. Recommendation for changes: Protocol change  Policy change  Educational change  Information sharing  None
20. Comments: \_\_\_\_\_  
\_\_\_\_\_
21. Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_  
(please print)
22. Title: \_\_\_\_\_ Phone number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext.: \_\_\_\_\_
23. School address: \_\_\_\_\_
24. Email address: \_\_\_\_\_ Fax number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_