

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

**Report of EpiPen® Administration**

*Please mail form to:*

**Janet Burke**

**MDPH**

**School Health Unit**

**250 Washington St., 5<sup>th</sup> Floor**

**Boston, MA 02108-4619**

School District: \_\_\_\_\_ Date/Time of occurrence: \_\_\_\_\_

Age of student: \_\_\_\_\_ Gender: M F Diagnosis/history of Asthma: *(Please circle response)* Yes No

Known allergen(s): \_\_\_\_\_

Trigger that precipitated this allergic episode: \_\_\_\_\_

Symptoms: \_\_\_\_\_

Location of student when symptoms developed: \_\_\_\_\_

Location of student when EpiPen® administered: \_\_\_\_\_

Location of EpiPen® storage: \_\_\_\_\_

EpiPen® administered by: *(Please circle response)* RN Other If other, please specify \_\_\_\_\_

If other than an RN, was this person formally trained? *(Please circle response)* Yes No Date of training \_\_\_\_\_

If EpiPen® was self-administered by a student at school or a school-sponsored function, did the student follow school protocols to notify school personnel and activate EMS? *(Please circle response)* Yes No NA

Approximate time between onset of symptoms and administration of Epi Pen®: \_\_\_\_\_

Individual Health Care Plan (IHCP) in place? *(Please circle response)* Yes No

Written school district policy on management of life-threatening allergies in place? *(Please circle response)* Yes No

School building emergency response team activated? *(Please circle response)* Yes No NA

Emergency Medical System:

Epinephrine available: *(Please circle response)* Yes No

Other emergency measures performed: \_\_\_\_\_

Disposition:

Outcome:

Recommendations for changes/improvements to current policy or procedures:

Form Completed By: \_\_\_\_\_

Date: \_\_\_\_\_

Title: \_\_\_\_\_

Phone number: \_\_\_\_\_

Address: \_\_\_\_\_