

Maine Department of Education
School Health Report

Epinephrine Autoinjector Administration **STUDENT**

Please send form to:

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School District/school: _____ 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 epinephrine administered: _____

Location of epinephrine® storage: _____

Dose given: 0.15 mg. 0.30 mg. 2nd dose given Yes No Exp. Date: _____

Epinephrine administered by: (Please circle response) 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 a student at school or a school-sponsored function, did the student follow school protocols to notify school personnel and activate EMS? Yes No NA

Approximate amount of time between onset of symptoms and administration of epinephrine: _____

Individual Health Care Plan for allergy (IHCP) in place? Yes No

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

School building emergency response team activated? Yes No NA

Emergency Medical System:

Epinephrine available: Yes No

Other emergency measures performed: _____

Disposition:

Outcome:

Recommendations for changes/improvements to current policy or procedures:

Form completed by: _____

Date: _____

Title: _____

Phone: _____