# Severe Allergic Reaction and/or Epinephrine Administration Report

# CDE School Health Services Office | 2025-2026

## WORKSHEET

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 experienced  severe allergic reaction | Use numbers and decimals only |  |
| The person who experienced  severe allergic reaction was a: | **Student/Non-student** |  |
| Does the person have  a 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 storage  Please 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 of  symptoms 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 |  |  |