

Bellevue School District -- ANAPHYLAXIS REPORT -- 3420P Exhibit A

Student Demographics and Health History			
Date:	Time:	School Name	
Student:		DOB:	Age:
History of severe or life-threatening allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If yes			
<ul style="list-style-type: none"> • History of anaphylaxis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown • Previous epinephrine use? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown • Diagnosis/History of asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 			

School Plans and Medical Orders
Individual Health Plan in place? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Does the student have a student specific order for epinephrine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Epinephrine Administration Incident Reporting
Vital Signs: B.P.: _____ Pulse: _____ Respirations: _____ O2 sat: _____
If known, specify the trigger that precipitated this allergic episode:
<input type="checkbox"/> Food <input type="checkbox"/> Insect Sting <input type="checkbox"/> Exercise <input type="checkbox"/> Medication <input type="checkbox"/> Latex <input type="checkbox"/> Other: _____
If food, please list: _____
Did reaction begin prior to school? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Location where symptoms developed;
<input type="checkbox"/> Classroom <input type="checkbox"/> Cafeteria <input type="checkbox"/> Health Room <input type="checkbox"/> Playground <input type="checkbox"/> Bus <input type="checkbox"/> Other: _____
How did exposure occur?: _____

Respiratory Symptoms: <input type="checkbox"/> Cough <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Hoarse voice <input type="checkbox"/> Nasal congestion/runny nose <input type="checkbox"/> Swelling (throat, tongue) <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Stridor <input type="checkbox"/> Tightness (chest, throat) <input type="checkbox"/> Wheezing	GI Symptoms: <input type="checkbox"/> Abdominal discomfort <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Oral Itching <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting	Skin Symptoms <input type="checkbox"/> Angioedema <input type="checkbox"/> Flushing <input type="checkbox"/> General itching <input type="checkbox"/> General rash <input type="checkbox"/> Hives <input type="checkbox"/> Lip swelling <input type="checkbox"/> Localized rash <input type="checkbox"/> Pale	Cardiac/Vascular Symptoms <input type="checkbox"/> Chest discomfort <input type="checkbox"/> Cyanosis (blue) <input type="checkbox"/> Dizziness <input type="checkbox"/> Faint/weak pulse <input type="checkbox"/> Headache <input type="checkbox"/> Hypotension <input type="checkbox"/> Tachycardia	Other Symptoms <input type="checkbox"/> Diaphoresis (sweating) <input type="checkbox"/> Irritability <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Metallic taste <input type="checkbox"/> Red eyes <input type="checkbox"/> Sneezing <input type="checkbox"/> Uterine cramps
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Medication Administration
Epinephrine IM autoinjector:
<ul style="list-style-type: none"> • Time of Administration: _____ • Dose: <input type="checkbox"/> 0.15mg <input type="checkbox"/> 0.30mg • Site of Injection: _____ • Location of where it was administered: <input type="checkbox"/> Health Room <input type="checkbox"/> Other: _____ • Administered by: _____

Epinephrine IM autoinjector: (DOSE 2 if ordered)

- Time of Administration: _____
- Dose: 0.15mg 0.30mg
- Site of Injection: _____
- Location of where it was administered: Health Room Other: _____
- Administered by: _____

Antihistamine: _____

- Time of Administration: _____
- Dose: _____
- Site of Injection: _____
- Location of where it was administered: Health Room Other: _____
- Administered by: _____

Bronchodilator/Inhaler: _____

- Time of Administration: _____
- Dose: _____
- Location of where it was administered: Health Room Other: _____
- Administered by: _____

Disposition

EMS Notified: _____ (time)

- Transferred to ER: Yes No Unknown
- If yes, transferred via: Ambulance Parent/Guardian Other: _____

Parent/Guardian Notified: _____ (time)

- Parent: At school Will Come to School Will Meet student at hospital
 Other: _____

Comments: _____

PARENT NOTIFICATION *This form must be sent home with student on the same day as event.*

Who was contacted: _____ Date: _____ Time: _____

Reporting Person: _____ Title: _____

Form completed by

Name: _____ Title: _____

Phone Number: (_____) - _____ - _____

Email: _____

Please make copies of this completed form and send to: 1) Parent/guardian 2) Special Education Supervisor for Health Services 3) Office of Superintendent