Use your "Mouse" or "Tab" key to move through the fields and check boxes. After completing last field, save document to hard drive to make future updates or click Print button.

# Illinois State Board of Education

100 North First Street
Springfield, Illinois 62777-0001

## UNDESIGNATED EPINEPHRINE REPORTING FORM

## WELLNESS DEPARTMENT

**Directions**: This form must be completed within three (3) calendar days after the administration of any undesignated epinephrine auto-injector. All completed forms must be submitted via online collection portal webpage.

| DISTRICT NAME AND NUMBER | RCDT CODE [Click Here to Find Code] | NAME OF SCHOOL |
|---|---|---|
| | | |

| ADDRESS (Street, City, State, ZIP Code) | CONTACT PERSON COMPLETING FORM |
|---|---|
| | |
| TELEPHONE (Include Area Code) | CONTACT EMAIL |
| | |
| DATE OF INCIDENT | TIME OF INCIDENT<br>_____ a.m. _____ p.m. |
| | |

1. Age of individual receiving epinephrine: _____
2. Description of person receiving epinephrine: ***(Check one only)***
   - ☐ a. Student
   - ☐ b. Staff member
   - ☐ c. Visitor
   - ☐ d. Other (please specify) _____
3. Was there any previously known diagnosis of a severe allergy?
   - ☐ a. Yes
   - ☐ b. No
4. Trigger that precipitated this allergic episode: ***(Check all that apply)***
   - ☐ a. Food (specific food if known) _____
   - ☐ b. Drug (specific drug if known) _____
   - ☐ c. Insect (specific insect if known) _____
   - ☐ d. Other (please specify) _____
5. Location of where symptoms developed: ***(Check one only)***
   - ☐ a. Within school building
   - ☐ b. On school grounds
   - ☐ c. Other (e.g., school activity location, field trip location, etc.) _____
6. Number of doses administered: _____
7. Type of person administering the epinephrine: ***(Check one only)***
   - ☐ a. Registered Nurse
   - ☐ b. Trained Personnel
   - ☐ c. Student
   - ☐ d. Other (please specify) _____

Comments ***(Please contain your response into the space provided)***:



Print Reset Form