

**ILLINOIS STATE BOARD OF EDUCATION**

Special Education Services Division

100 West Randolph, Suite 14-300

Chicago, Illinois 60602

**UNDESIGNATED EPINEPHRINE REPORTING FORM**

**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 e-mailed to [epinephrine@isbe.net](mailto:epinephrine@isbe.net).

DISTRICT NAME AND NUMBER	NAME OF SCHOOL
ADDRESS (Street, City, State, Zip Code)	CONTACT PERSON COMPLETING FORM
TELEPHONE (Include Area Code)	CONTACT E-MAIL
DATE OF INCIDENT	TIME OF INCIDENT _____ a.m. _____ p.m.

- Age of individual receiving epinephrine: \_\_\_\_\_
- Description of person receiving epinephrine: **(Check one only)**
  - a. Student
  - b. Staff member
  - c. Visitor
  - d. Other (please specify) \_\_\_\_\_
- Was there any previously known diagnosis of a severe allergy?
  - a. Yes
  - b. No
- 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) \_\_\_\_\_
- 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.) \_\_\_\_\_
- Number of doses administered: \_\_\_\_\_
- Type of person administering the epinephrine: **(Check one only)**
  - a. Registered Nurse
  - b. Trained Personnel
  - c. Student
  - d. Other (please specify) \_\_\_\_\_

Comments (do not go beyond space provided):