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.

DISTRICT NAME AND NUMBER	NAME OF SCHOOL
ROCKFORD PUBLIC SCHOOL #205	WELSH ELEMENTARY
ADDRESS (Street, City, State, Zip Code)	CONTACT PERSON COMPLETING FORM
501 7th ST. ROCKFORD IL	CHERYL ERICKSON RN
TELEPHONE (Include Area Code)	CONTACT E-MAIL
815-966-3000	ERICKSCO RPS 205. COM
DATE OF INCIDENT	TIME OF INCIDENT
4/13/18	8:18 (a.m.) p.m.

1. Age of individual receiving epinephrine: 10
2. Description of person receiving epinephrine: ***(Check one only)***
   - [x] a. Student
   - [ ] b. Staff member
   - [ ] c. Visitor
   - [ ] d. Other (please specify) ______
3. Was there any previously known diagnosis of a severe allergy?
   - [ ] a. Yes
   - [x] 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) ______
   - [x] d. Other (please specify) UNKNOWN - HE WAS IN ART CLASS -
5. Location of where symptoms developed: ***(Check one only)***
   - [x] a. Within school building
   - [ ] b. On school grounds
   - [ ] c. Other (e.g., school activity location, field trip location, etc.) ______
6. Number of doses administered: 1
7. Type of person administering the epinephrine: ***(Check one only)***
   - [x] a. Registered Nurse
   - [ ] b. Trained Personnel
   - [ ] c. Student
   - [ ] d. Other (please specify) ______

Comments (do not go beyond space provided):

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DISTRICT NAME AND NUMBER #205 Rockford Public Schools	NAME OF SCHOOL Lathrop School
ADDRESS (Street, City, State, Zip Code) 2603 Clover Ave. Rockford, IL 61102	CONTACT PERSON COMPLETING FORM Erlinda Danielson
TELEPHONE (Include Area Code) (815-966-5278	CONTACT E-MAIL
DATE OF INCIDENT 10/23/2017	TIME OF INCIDENT 1230 a.m. ____ p.m. (circled)

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) etiology unknown
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: 1
7. 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): SOB, coughing, facial hives