EPINEPHRINE USAGE REPORT

Organization Name: _____Agency Code: _____

Agency Type: □ Ambulance Service □ BLS First Responder □ ALS First Responder
□ Day Camp □ Overnight Camp □ Traveling Camp

Patient Information
□ Female □ Male Age: _____ Weight: _____
If at a Camp, Patient's Status: □ Camper □ Staff □ Counselor □ Other

Incident Information
Date of Incident _____/_____/_____Time of Incident: _____ ___□ A.M. □ P.M.
Location of Incident: □ Camp or Camp Trip □ Home □ Specify:_____

Type of Incident Resulting in Need to Administer Epinephrine:
□ Bee Sting □ Other Insect Bite □ Asthma Attack □ Food Allergy □ Other
Specify Event:_____

Does the patient have a known prior history of allergy to the substance?_____
Was medical control established, if needed:_____ Physician Name or #:_____

Administration Information
Time Epinephrine was administered:_____ □A.M. □ P.M.
Where on body was epinephrine injected?_____
Number of auto-injector administrations: _____
Type of Epinephrine Injector: □ Epi-pen® □ Epi-pen Jr.® □ Syringe epinephrine kit
□ Other (specify)_____

Indicate source of Auto-Injector: □ Camp supply □ Patient's prescription □ Other (specify):
_____

Administered by:_____ EMT#:_____
Indicate applicable certification(s):
□ Doctor □ RN □ EMT □ AEMT □ Self Administered □ Other _____

Epinephrine training course: □ NYS EMS □ Red Cross □ Other _____
Name of EMS agency providing transport:_____
Name of hospital emergency department patient was transported to: _____
PCR #:_____

Was patient admitted? □ Yes □ No □ Not Sure
Was the agency's Medical Director notified of the incident within 24 hours? □Yes □ No

This form is to be completed and sent within 5 business days of the use of Epinephrine.
Send the form via email, fax, mail to: PAPERWORK@FDRHPO.ORG By Fax to: 315-755-0717
or mail to: FDRHPO EMS Program Agency
120 Washington Street, Suite 230
Watertown, NY 13601