Appendix E: Anaphylaxis Worksheet

Demographic Information:

Client Name: ______________________ **DOB:** __________

Address: ______________________ **Gender:** Male ☐ Female ☐

Phone Number: ______________________ **PHN:** __________

Immunization(s) Administered:

Vaccine	Lot Number	Date	Time	Route	Site

Assessment and Treatment Information:

Time	Pulse	Resp.	L.O.C	Skin	Drug	Dose	Route

Notes:

Allergic Symptom Onset Date: __________ **Time:** __________

Time EMS Activated: __________ **Time Transferred to Hospital:** __________

Presenting Symptoms: __________

Follow-up Information:

Notified	Time	By	Notified	Time	By
Parents/Guardian			Supervisor, Immunization Program		
MOH/MOH designate			School Principal		
Program Manager			Physician		

Public Health Nurse: ______________________ Date: __________