

MEDICAL EVENT REPORT

**Contact District Health Services Coordinator and an ALOA Administrator by phone
as soon as possible after event**

Fax report within 1 business day. District Fax#: 5346 Do NOT Email Report

Name of School _____ Date of Event _____ Time of Event _____

Called: 911 ☐ Parent only ☐

Emergency **Inhaler** Given ☐
Inhaler not available ☐
Emergency **Seizure** Med Given ☐
Emergency **Epinephrine** Given ☐
Emergency **Glucagon** Given ☐

Name of Person Experiencing Event _____ D.O.B. _____ Event Code _____

(If student, include student ID #)

Person Experiencing Event

- ☐ Student
☐ Staff
☐ Visitor

Transported by:

EMS ☐ LifeFlight ☐

Hospital: _____ ☐

Who went with: _____ ☐

Transported by Parent ☐

Home: _____ ☐

Hospital: _____ ☐

Doctor or Urgent Care ☐

Position of Person Witnessing/Describing the Event _____

Describe event: _____

Persons notified:

Title	Name	Date	Time
Principal			
Parent/Family Member			
RN Supervisor			
ALOA Administration			
District School Health Coordinator 850-469-5456			

850-439-2681

Signature (person completing report) _____

Date Completed _____

Follow-up information if applicable (to be completed by School Health Office/Coordinator):

Event Codes:

1. Allergic Reaction/Allergy Hx

2. Bleeding

3. Breathing/Asthma

4. Cardiac/Chest Pain

5. Diabetes/Glucagon

6. Dizziness/Fainting

7. Environmental

8. Possible Drug Overdose/Poisoning

9. Injury/Fall

10. Numbness/Tingling

11. Pain (Severe)

12. Choking

13. Seizure/Emergency Med

14. Unresponsiveness

15. Other

