**REGIONAL EMERGENCY MEDICAL ORGANIZATION (REMO)**

**EPINEPHRINE USAGE REPORT**

<table>
<thead>
<tr>
<th>Organization Name:</th>
<th>Agency Code:</th>
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<tbody>
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**Agency Type:**
- Ambulance Service
- BLS First Responder
- ALS First Responder
- Day Camp
- Overnight Camp
- Traveling Camp

**Patient Information**

<table>
<thead>
<tr>
<th>Sex:</th>
<th>Age:</th>
<th>Weight:</th>
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<tbody>
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If at a Camp, Patient’s Status:
- Camper
- Staff
- Counselor
- Other

**Incident Information**

<table>
<thead>
<tr>
<th>Date of Incident:</th>
<th>Time of Incident:</th>
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<tbody>
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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**

<table>
<thead>
<tr>
<th>Time Epinephrine was administered:</th>
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<tbody>
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</table>

Type of medication administration:
- ___ Autoinjector  
  # of times auto-injector administered______

Type of Epinephrine Injector:
- Epi-pen®  
- Epi-pen Jr.®
- Other: __________________________

Indicate source of Auto-Injector:
- ___ Camp supply
- ___ Patient’s prescription
- Other (specify): __________________________

OR
- ___ Check and inject
  Dosage administered______  
  # of times administered______

Where on body was epinephrine injected? ______________________

Administered by: _________________________________________

Indicate applicable certification(s):
- Doctor
- RN
- EMT
- AEMT
- Self Administered
- Other: __________________________

Certification/license #: ______________

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 hrs?  Yes  No

Complete this form and send to REMO within 2 business days of the use of epinephrine. Send the form via email (medicalstandards@remo-ems.com; fax (464-5099) or mail to:

REMO
Attn: Epinephrine administration
431 New Karner Road
Albany, NY 12205