

Episode Observation Form — Child

To be completed by parents, nursery staff, childminder or teachers

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■ General information

Child's name: _____

Date of birth: _____

Observer (name / role): _____

Location: _____

Date and time of episode: _____

■ 1. Possible trigger (tick one or more)

- | | |
|--|--|
| <input type="checkbox"/> Specific food: | <input type="checkbox"/> Heat / sun / physical effort |
| <input type="checkbox"/> Tomato | <input type="checkbox"/> Stress / frustration / excitement |
| <input type="checkbox"/> Citrus fruits | <input type="checkbox"/> Smells / household products / perfume |
| <input type="checkbox"/> Chocolate / cocoa | <input type="checkbox"/> Onset of infection (fever, cold...) |
| <input type="checkbox"/> Dairy products | <input type="checkbox"/> No identifiable trigger |
| <input type="checkbox"/> Strawberry | |
| <input type="checkbox"/> Fermented food | |
| <input type="checkbox"/> Other: _____ | |

■ 2. Systems affected — tick all that occurred (within 60–90 min of the episode)

A. Skin

- Sudden redness
- Hives / urticaria
- Dermographism (skin marks on light touch)
- Swelling (eyelids, lips, fingers)
- Itching (eyes, face, body)

B. Digestive

- Abdominal pain
- Sudden diarrhoea
- Vomiting
- Reflux / excessive drooling
- Sudden food refusal

C. Respiratory

- Sudden cough
- Rapid / wheezing breathing
- Changed voice
- Gasping / respiratory agitation

D. Cardiovascular / autonomic

- Sudden pallor
- Sweating
- Sudden fatigue / limpness
- Unusual excitement / agitation
- Trembling
- Tachycardia (if measured)

E. Neurological / behavioural

- "Topsy", lightheaded, confused
- Sudden irritability
- Unexplained crying episode
- Sensitivity to noise / light
- Blank stare / disconnection
- Balance problems

■ If several categories are ticked → likely multi-systemic episode.

■ 3. Severity

- Mild Moderate Significant Very severe

■ 4. Duration of episode