

Adrenal Insufficiency Emergency Action Plan and Medication Order for School/Childcare

Date: _____

Name: _____

Date of Birth: _____

School: _____

Grade: _____

Emergency Contact: _____

Phone: _____

Treating Provider: _____

Phone: _____

Place
student
photo here**Medication Authorization**

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices and release the school and personnel from any liability in compliance with their Board of Education policies.

Healthcare Provider Signature: _____

Date: _____

Parent/Guardian's Signature: _____

Date: _____

School Nurse/CCHC: _____

Date: _____

Green Zone		
Maintenance Medication (Daily Medication)		1. Maintenance medication used daily: _____ mg of _____ at _____ at school. 2. N/A if nothing at school _____.
If you see this:		Do this:
Yellow Zone		
Moderate illness or stress: <ul style="list-style-type: none"> ➤ Fever over 100.4°F degrees ➤ Vomiting ➤ Diarrhea ➤ Moderate trauma (i.e. single broken bone without breaking the skin). 		Staff trained and delegated to administer medications <ol style="list-style-type: none"> 1. Administer _____ mg of Hydrocortisone one time or every _____ hours. 2. Notify parent or emergency contact. 3. Contact school RN at _____
Red Zone		
MAJOR illness or stress: <ul style="list-style-type: none"> ➤ Unable to take oral medication. ➤ Unconscious ➤ Continuous vomiting or diarrhea ➤ Severe physical injury ➤ Severe emotional distress ➤ _____ ➤ _____ 		Staff trained and delegated to administer Solu-Cortef® <ol style="list-style-type: none"> 1. Call 911 for transport (Alert EMS of adrenal insufficiency) 2. Administer Solu-Cortef® (dose _____ mg) intramuscularly 3. Check temperature 4. Provide additional clothing or blankets as needed for cold sensitivity 5. Provide copy of health care plan to EMS 6. Notify parent or emergency contact 7. Contact school nurse at _____

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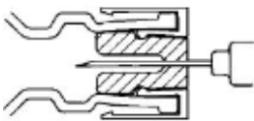
Grade: _____

Emergency Contact: _____

Phone: _____

Treating Provider: _____

Phone: _____



Instructions for the Solu-Cortef® Act-O-Vial (100mg/2ml)

1. Press down the plastic activator on the Solu-Cortef® Act-O-Vial (100mg/2ml or 250mg/2ml) so that the liquid enters the powder section.
2. Mix gently by shaking or rolling until the mixture is clear.
3. Remove plastic tab covering center of stopper
4. Clean the rubber stopper with alcohol.
5. Stick the needle through center of the rubber stopper until tip is just visible. Then turn the bottle upside down (with the needle still in it) and draw up of the mixture into the syringe.
6. Inject into the thigh

Solu-Cortef® Dose: _____

Additional Notes:

Staff Trained and Delegated to Give Emergency Medications:

Place
student
photo here

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