TRAINING, DELEGATION AUTHORIZATION AND SUPERVISION RECORD – EMERGENCY RESPONSE TO ADRENAL INSUFFICIENCY

Name Student/Child	Birth Date:	School/ Center	Delegatee: Unlicensed Assistive Personnel (UAP)

PROCEDURE *Congenital Adrenal Hyperlplasia means the body cannot make enough of the stress hormones necessary for the body to respond to stressful situations, illness or injury. Emergency medication must be given in times of stress.*	Training Record **RN Initial & Date**
A. States purpose of procedure and location of medication and supplies	
B. Identifies supplies –Individualized Healthcare Plan (IHP), Solu-Cortef, Alcohol wipes, 3mL syringe, vial adaptor or additional syringe needle, gloves, sharps container, tissue Cotton ball	
C. Procedure:	
1. Gather supplies and bring to the student.	
2. Wash hands and put on gloves. • Read the label to ensure you have the correct Solu-Cortef vial concentration • Check the expiration date.	
3. Press down on the top of the Solu-Cortef® Mix-O-Vial.	
4. Gently roll the vial until the powder is clear without particles. Mixing takes about 30 seconds.	
5. Remove the plastic cap on the stopper.	
6. Clean the rubber top of stopper with alcohol.	
7. Stick the needle through the rubber top. Turn the bottle upside down with the needle still in it.	
8. Draw up _____ mL of the mixture into the syringe. This equals ____ milligrams.	
9. Expel any air bubbles from the syringe.	
10. Clean the skin with alcohol. Inject into a muscular part of the thigh, hold for 10 seconds and press firmly down on the site for a few seconds.	
11. Place used syringe in the sharps container. The injection will work quickly. Supervision of the student is still required.	
12. Reassure student. Student needs to be seen by doctor.	
13. Call EMS (911) as directed in Individualized Healthcare Plan. Provide EMS with a copy of plan.	
14. Call parents. Call RN.	
Competency Statement	**Training RN Signature & Initial**
Procedure name: Describes and demonstrates correct performance of intramuscular injection of solu-cortef. .	

DELEGATION AUTHORIZATION

I have read the care/medication plan, been trained and am competent in the described procedures for _____. I understand the need to maintain skills and will be observed on an ongoing basis by a Registered Nurse. I have had the opportunity to ask questions and received satisfactory answers.

Delegatee Signature: _____ Date _____

Delegating RN Signature: _____ Initials ____ Date _____

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RN Initial & Date	**Procedure** √ = acceptable performance	**Follow Up/ Supervision Plan / Comments**
	☐ Procedure Reviewed ☐ Solu-Cortef administration ☐ ☐ ☐IHP accessible and current ☐Competent performance of procedure(s) per specific guidelines ☐Confidentiality ☐Documentation ☐RN notification of change in status ☐Child/student tolerating procedure well	☐No opportunity to perform task. ☐Simulated emergency response practice. ☐Additional on-site training provided ☐Supervision plan (minimum annually) date: ______ ☐Continue delegation ☐Withdraw delegation Comments:
	☐ Procedure Reviewed ☐ ☐ ☐ ☐IHP accessible and current ☐Competent performance of procedure(s) per specific guidelines ☐Confidentiality ☐Documentation ☐RN notification of change in status ☐Child/student tolerating procedure well	☐No opportunity to perform task. ☐ Simulated emergency response practice. ☐Additional on-site training provided ☐Supervision plan (minimum annually) date: ______ ☐Continue delegation ☐Withdraw delegation Comments:
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Delegating RN Signature ____ Initials _____