Carroll ISD Health Services
Parental Authorization for Solu-Cortef IM

Parent please answer:	
Special Ed services?	yes / no
Active 504 plan?	yes / no
I would like 504 information	yes / no

Student's Name: _____

Date of Birth: _____ Grade: _____ School: _____

This is a letter for our patient _____, who has a diagnosis of _____. This condition can result in acute crisis that can be a life-threatening state caused by insufficient levels of cortisol, which is a hormone produced and released by the adrenal gland. An intramuscular injection (IM) of Solu-Cortef (an injectable corticosteroid) must be given as soon as possible to increase the chance for a quick recovery. Risk factors for **adrenal crisis** include physical stress such as infection, illness, dehydration, or trauma. In situations where one or more of the risk factors are present, IM Solu-Cortef is required.

For one or more of the **checked** symptoms below administer Solu-Cortef _____ ml, which is _____mg IM. This injection should be given immediately, and the patient should be promptly evaluated by a physician in the nearest emergency room (dial 911).

□ severe illness	□ chills
□ fever of ≥100 degrees F	□ irregular heart beat
□ shortness of breath	□ sudden confusion/unconsciousness
□ trauma	□ other

I, the parent or guardian of _____(student's name), agree with his/her physician to allow the **registered nurse (only)** to administer the above prescribed dose of Solu-Cortef IM to my son/daughter _____(student's name). I understand that **no school staff** other than the registered nurse will be able to administer Solu-Cortef IM. In a situation where the registered nurse is off campus, the school staff will respond to my child's condition as an emergency and will immediately phone 911 for prompt medical care. The school staff will also make every attempt to send the available Solu-Cortef and the physician orders with the paramedics to the emergency room.

Parent or Guardian accepts responsibility for the following:

1. Providing Solu-Cortef (un-expired vial) to the school nurse upon student enrolling in Carroll ISD. Medication must be properly labeled from the pharmacy.
2. Promptly communicating changes in the students physical condition with the school nurse and/or school staff.
3. Provide updated Action Plan yearly and for changes in emergency doses signed by the physician.
4. Provide and keep current emergency numbers to be used for contacting parent in case of emergency.
5. Will discuss with the school nurse side effects observed from previous Solu-Cortef IM injections, if any.

Reviewed 9-2019

Action for Major Reaction:

1. Give above prescribed dose of IM Solu-Cortef
2. Call 911
3. Call parent(s) or guardian(s): Contact Number(s)

(____)_____ (____)_____ (____)_____

Parent Consent to Share Information and Picture

I ____ do / ____ do not (check one) authorize Carroll ISD to display a picture of my child and identify that this is a person with adrenal insufficiency. I understand that school staff that comes into contact with my child will be given (nature of the condition) information about my child that would assist them in an emergency situation. This may include but is not limited to: health office staff and substitutes, classroom teachers and aides, special subject teachers, substitute teachers, office staff, cafeteria staff and bus drivers. I understand that the reason for this is to enable school personnel to better prevent and respond to potential emergencies. This authorization is valid from the date signed for the remainder of the current school year. Parent Initials____

Parent/Guardian Authorization for School Staff to Communicate Health Information

I authorize the District's designees, including District medical professionals and UAPs, to share/obtain my student's health related information with the medical health professional or health care provider identified above to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP, or other PISD form requesting for school health care services. By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate, and no longer be protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury. I hereby release any Health Care Provider that acts in reliance on this Authorization from any liability that may accrue from releasing my child's Individually Identifiable Health Information. School-related health services described herein shall not be provided to a student without the required consent of the parent/guardian, as outlined herein. Parent initials _____

Parent/Guardian Release of Claims Against District and Agreement to Indemnify

To the extent permitted under the law, on behalf of myself and the student, I release and agree to defend, indemnify, and hold harmless the District for all claims, damages, demands, or

actions arising from, relating to or growing out of, directly or indirectly, the administration of Medication to the Student and/or the disclosure of Individually Identifiable Health Information. This release is to be construed as broadly as possible. It includes a release of claims against the District for its, joint or singular, sole or contributory, negligence or strict liability, including liability arising from the alleged violation of any statute (other than those which protect against discrimination based on race, age, sex, or other classification which has experienced historical discrimination), growing out of, relating to, or arising out of, directly or indirectly, the School Staff's administration of medication described in this document to the student and/or the disclosure of Individually Identifiable Health Information,, including but not limited to claims that School Staff negligently failed to recognize symptoms requiring the use of my child's Medication, misconstrued symptoms which it believed necessitated the use of my child's Medication, negligently administered or failed to administer Solu-Cortef Medication(s), and/or "over-disclosed" my child's Individually Identifiable Health Information.

The School Health Administrative Guidelines developed by the Carroll Independent School District are subject to the Americans with Disabilities Act ("ADA"), 42 U.S.C. §12101, et seq.; Section 504 of the Rehabilitation Act of 1973 ("Section 504"), 29 U.S.C. § 701, et seq.; and the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1400 et seq.

DO NOT HESITATE TO ADMINISTER IM MEDICATION OR CALL EMERGENCY MEDICAL SERVICES, EVEN IF PARENTS CANNOT BE REACHED.

By signing below, I certify that I have read and understand the above information.

Parent's/Guardian's Name	Parent Phone No.
Parent's/Guardian's Signature	Date
Physician's Name	Physician' Phone No.
Physician's Signature	Date