

(Parent/Guardian Signature)

Pringerville ISD * Health Services EMERGENCY ACTION PLAN FOR ADRENAL INSUFFICIENCY

Student's Name:	ID #	DOB:	Weight:	Grade:
Medical diagnosis/conditions:				
Allergies:				
-				
THIS SECTION TO B	E COMPLETEI	AND SIGNED	BY PHYSICIA	N
**Indications for Solu-Cortef IM injection	(be specific/check	all that apply):		
☐ repeated vomiting	☐ trauma or r	najor injury		
☐ signs of dehydration		arrhea episodes		
☐ fever greater thanF°			ss of consciousness	
severe pain in stomach, legs or back	☐ irregular he	eart rate or HR gre	ater than	
<u> </u>				
Solu-Cortef <u>Intramuscular (IM)</u> injecti	on dosage:			
Self-Administration:				
Student has been instructed in the proper way			•	•
knowledgeable about this medication and has	the skills to safely	possess and use th	ne prescribed medi	cation.
☐ Yes ☐ No				
**Indications for oral stress dose (be specif	ic/check all that a	pply):		
□ vomiting (less thanepisodes)□ feverF°	injury	*11		
leverr	infection or	iliness		
<u> </u>				
Oral Stress Dosing: medication/dosage/frequ	iency:			
Cala Canta COM Sasta de la mello anho ha a dans		I X/NI	4 1 1	··· 4 -
Solu-Cortef IM injection will only be admi	*		_	
self-administer. If solu-cortef injection is add		~ .	,	
Solu-Cortef injection is administered, and the				
parent/guardian to provide appropriate medica			* *	
when no nurse is available, school staff will	· · · · · · · · · · · · · · · · · · ·		inister medicatioi	1 II ordered, contact
the parent, and monitor and support stude	_			
I request and authorize the above medicat	ion(s), dosage and	frequency.		
(Physician/Healthcare provider Signature)	(Print Name)	(Da	te)	(Phone)
THIS SECTION REC	QUIRES A PARI	ENT/GUARDIA	N SIGNATURI	£
*Notice of Parent and Student Rights Under Se	ction 504: Based on	information provide	ed on this Emergency	y Action Plan, your
child may be eligible for Section 504 consideration	n. Please review the a	attached Notice of P	arent & Student Rig	hts Under Section 504
of the Rehabilitation Act of 1973. If you have any	questions about Sect	ion 504 eligibility o	r the evaluation prod	cess, please contact the
504 Coordinator at your child's campus. Signatur				
*Notice To Parent/Guardian of Students Attend			=	-
school day and who require "as needed" medication			•	•
deliver the medication to both campuses and meet				eds.
*This form must be updated every year. A new *I consent to the above treatment plan and aut				dication(s)
I consent to the above treatment plan and auth	norize uesigilateu sc	movi stam to aumilli	uster the above med	.icauoii(5 <i>)</i> .

(Print Name)

(Date)

(Phone)