FREEHOLD REGIONAL HIGH SCHOOL DISTRICT
HYDROCORTISONE SODIUM SUCCINATE MEDICATION ORDER

Student Name:_____ Grade:_____ School: _____

1.PERMISSION TO ADMINISTER HYDROCORTISONE SODIUM SUCCINATE
2.PERMISSION OR REFUSAL TO APPOINT DESIGNEE

1) Our child, _____, requires the administration of Hydrocortisone Sodium Succinate for adrenal insufficiency in the case of adrenal crisis. We understand that we must submit to the School Nurse written orders from a health care provider indicating that our child requires the administration of the medication. We further understand that we must provide the school with current unexpired medication and supplies, that we are responsible for replacing when the medication has expired or has been used, and that we shall pick it up at the end of the school year. Our permission is effective for the school year for which it is granted. We understand that it must be renewed for each subsequent school year.

We understand that the School Nurse will be available during the standard school day but will not be available at school sponsored events or after school activities in the event of a situation requiring the administration of Hydrocortisone Sodium Succinate. The trained designee, if appointed, will be available during school hours and at school sponsored events. We realize it's our responsibility to inform the school in a timely manner of the school sponsored event in which our child will participate. We further understand that the designees may be assigned to the students who are qualified to self administer their emergency medications, as well as to those who are not qualified to self administer. In the event that we decline to have a designee appointed, we also understand that there will not be a nurse at school sponsored events occurring outside the standard school day.

Pursuant to N.J.S.A. 18 A: 40-12.33, we acknowledge our understanding that the Freehold Regional High School District, its employees and agents shall have no liability as a result of any injury arising from the administration of Hydrocortisone Sodium Succinate to our child, and we indemnify and hold harmless the district and its employees or agents against claims arising out of the administration of Hydrocortisone Sodium Succinate to our child.

We hereby grant permission to the School Nurse or Medical Inspector to administer Hydrocortisone Sodium Succinate in tablet form or via intramuscular injection to treat our child for adrenal insufficiency or adrenal crisis.

_____ _____
Parent /Guardian signature Date

2) We **authorize** the School Nurse to designate and train one or more employee volunteers of the Freehold Regional High School District to administer Hydrocortisone Sodium Succinate via tablet or intramuscular injection to our child in case of emergency when the School Nurse or Medical Inspector is not present.

We understand that no other medications may be administered by the designee and that the Hydrocortisone Sodium Succinate, via tablet or intramuscular injection, will be administered by the designee according to the orders provided by our child's Health Care provider

_____ _____
Parent /Guardian signature Date

We **DO NOT** authorize the School Nurse to designate one or more employees of the Freehold Regional High School District to administer Hydrocortisone Sodium Succinate via tablet or intramuscular injection to our child. We understand that a nurse will not be available during school sponsored events outside the standard school day and that 911 will be activated in the event of adrenal insufficiency or adrenal crisis.

_____ _____
Parent /Guardian signature Date

FREEHOLD REGIONAL HIGH SCHOOL DISTRICT
HYDROCORTISONE SODIUM SUCCINATE MEDICATION ORDER

STEP 1. Determine how to treat a reaction promptly. Adrenal Insufficiency (AI) is a disease where the body does not produce stress hormones. Certain illnesses and injuries may cause a person with AI to experience an Adrenal Crisis. Adrenal Crisis may be life threatening if not treated promptly with medication called Hydrocortisone Sodium Succinate (abbreviated below as H.S.S.) It may be administered in Pill Form or by Intramuscular Injection (IM)

Symptoms	**Give Checked Medication** (To Be Determined by by Physician Authorizing Treatment)		
Fever > 100.5 F	☐ Pill H.S.S_____mg	☐ IM H.S.S. _____ mg	☐ NO TREATMENT
Mild Illness (Cold Runny nose)	☐ Pill H.S.S_____mg	☐ IM H.S.S. _____ mg	☐ NO TREATMENT
Fever > 102 F	☐ Pill H.S.S_____mg	☐ IM H.S.S. _____ mg	☐ NO TREATMENT
Severe Illness (Vomiting, Diarrhea, Sore Throat Ear Infection, Pneumonia, Flu)	☐ Pill H.S.S_____mg	☐ IM H.S S. _____ _mg	☐ NO TREATMENT
Significant Trauma (Severe Bleeding, Broken Bones Loss of Consciousness)	☐ Pill H.S.S_____mg	☐ IM H.S.S. _____ mg	☐ NO TREATMENT
Significant Illness (Lethargy, Decreased Oral Intake Recurrent Vomiting/Diarrhea > 1 time)	☐ Pill H.S.S_____mg	☐ IM H.S.S. _____ mg	☐ NO TREATMENT
Other_____	☐ Pill H.S.S_____mg	☐ IM H.S.S. _____ mg	☐ NO TREATMENT
Other_____	☐ Pill H.S.S_____mg	☐ IM H.S.S. _____ mg	☐ NO TREATMENT
Other_____	☐ Pill H.S.S_____mg	☐ IM H.S.S. _____ mg	☐ NO TREATMENT

STEP 2. Call 911 if Hydrocortisone Sodium Succinate was administered. (Even if symptoms appear to have abated or decreased) Inform EMS that Hydrocortisone Sodium Succinate was administered for Adrenal Insufficiency.

FREEHOLD REGIONAL HIGH SCHOOL DISTRICT
HYDROCORTISONE SODIUM SUCCINATE MEDICATION ORDER

Emergency Contact Information

Parent/Guardian 1. Name_____

Emergency Cell Phone: (_____)_____-_____

Home telephone: (_____)_____-_____

Work Telephone: (_____)_____-_____

Parent/Guardian 2. Name_____

Emergency Cell Phone: (_____)_____-_____

Home Telephone: (_____)_____-_____

Work Telephone: (_____)_____-_____

***IF A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO ADMINISTER MEDICATION AND CALL 911 TO HAVE STUDENT TRANSPORTED TO A MEDICAL FACILITY**

TREATMENT PLAN FOR A DESIGNEE (DELEGATE) WHEN THE SCHOOL NURSE IS NOT PRESENT:

In accordance with N.J.S.A. 18A:40 12.29-12.33, the school nurse shall designate additional employees of the school district who volunteer to administer a one time dose of Hydrocortisone Sodium Succinate to a student exhibiting signs and symptoms of Adrenal Insufficiency to serve as delegates when the nurse is not physically present at the scene.

Please check and complete A or B

A._____ Delegate Order- For symptoms of Adrenal Insufficiency listed above, delegates are to immediately administer Hydrocortisone Sodium Succinate (tablets or via IM injection)

B._____ This student's order should NOT be delegated.

Health Care Practitioner's Stamp

Health Care Practitioner's Name: _____
Health Care Practitioner's Signature:_____

Date:_____

FREEHOLD REGIONAL HIGH SCHOOL DISTRICT
HYDROCORTISONE SODIUM SUCCINATE MEDICATION ORDER
REQUEST FOR STUDENT SELF-ADMINISTRATION OF MEDICATION

Student Name: _____ School: _____Grade: _____

Date of Birth: _____ Age: _____ ID#: _____

As per Board Policy and Regulation 5330, self-administration of medication by a student may be permitted for the treatment of asthma or other potentially life threatening illness, or a life threatening allergic reaction. A life threatening illness is defined as an illness or condition that requires an immediate response to specific symptoms and/or an after effect of disease or injury that if left untreated may lead to potential loss of life. All requests for self administration of medication are effective for one school year only and expire as of July 1st of each year.

****

SECTION ONE: To be completed by student's Private Physician

I certify that the student named above has a qualifying condition or illness that may require medication. I certify that the student has been instructed and is proficient in the proper method of self-administration of the prescribed medication, and is capable of self-carrying and self administration of the prescribed medication. I hereby request that the above named student be allowed to self-administer the following medication as prescribed by me:

Name of Medication: _____ Form of medication: _____

Diagnosis/Reason: _____ Purpose of medication: _____

Dosage: _____ Frequency: _____

Time Medication to be Self-Administered:_____

Special Instructions: _____

_____

Possible Side Effects: _____

_____

Date to Begin: _____ Date to Conclude:_____

_____ _____

Physician's Name (Printed/Typed) Address

_____ _____ _____

Physician's Signature Date Telephone Number
(Stamp not acceptable)

FREEHOLD REGIONAL HIGH SCHOOL DISTRICT
HYDROCORTISONE SODIUM SUCCINATE MEDICATION ORDER

****

SECTION TWO: To be completed by Parent(s)/Guardian(s)

I/We, as parent/guardian of _____, provide our express authorization and permission for _____ to self-administer _____ while in school and/or during school activities/athletics.

In accordance with Board Policy and Regulation 5330 and N.J.S.A. 18A:40-12.3, I/we have been advised, understand and acknowledge that the Board, the District and any of its employees or agents shall have no liability as a result of any injury to my child that is caused by or arises out of the self-administration of any medication.

I/We further understand and acknowledge that in accordance with N.J.S.A. 18A:40-12.3, I/we must indemnify and hold harmless the Board, the District and any of its employees or agents against any claims arising out of the self-administration.

I/We understand and acknowledge that the permission provided by this form is good for the current school year only and must be renewed for each subsequent school year.

_____ _____ _____

Signature of Parent/Guardian Date Emergency Telephone number

****

SECTION THREE: To be completed by school staff

After consultation with the School Nurse and School Medical Inspector, the request for self administering of medication by the student referenced above is hereby [**GRANTED/DENIED**] (select one).

_____ _____

Signature of School Principal Date

A copy of this completed form will be provided to the School Nurse and the student's parent(s)/ guardian(s).

In accordance with Board Policy and Regulation 5330, any request that is denied may be appealed to the Superintendent or his/her designee.