Grand Prairie ISD

Adrenal Crisis Action Plan

Administered only by School Nurse

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 (be specific) _____

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 Grand Prairie ISD. Medication must be properly labeled from the pharmacy.
2. Promptly communicating changes in the student's 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.

Parent Initials: _____

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/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 GPISD 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: _____

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's/Guardian's Signature Date

_____ _____

Physician's Name Physician' Phone No.

Physician's Signature Date