

Adrenal Crisis Rescue Authorization Emergency Action Plan (EAP)/Medication Order In accordance with UCA 53G-9-507 Utah Department of Health and Human Services/Utah State Board of Education		PHOTO	 NURSING & HEALTH SERVICES Phone 435-752-3925 Fax 435-792-7796	RN Approval Date:
Student information				
Student Name:	DOB: 12/25/25	Grade:	School:	SY:
Parent Name:	Phone:	Email:		
Physician:	Phone:	Fax/Email:		
District Nurse:	Phone:	Email:		
Medical Diagnosis(es):		Age at Diagnosis:		
Adrenal Crisis Emergency Action Plan				
Students with adrenal insufficiency conditions may also need a separate Section 504 plan in plan to provide accommodations necessary to access their education.				
Medical history:				
YELLOW: minor symptoms need <i>Stress Dose</i> If you see this:		Actions for <i>Stress Dose</i> (oral medication) Do this:		
If the student is experiencing any minor signs or symptoms below: ☐ Fever higher than _____. ☐ Vomiting once, or _____ times. ☐ Serious injury (broken bones, head injury, auto or bike accident) ☐ Other (specify):		1. Call parent/guardian 2. Give _____ tablet(s) of _____ (hydrocortisone) (5 mg tablets). 3. Offer small sips of water, sports drink, or clear carbonated beverage until a parent arrives if the medication was given due to vomiting. 4. Complete required documentation 5. Other (specify):		
RED: severe symptoms are an <i>Adrenal Crisis</i> If you see this:		Actions for <i>Adrenal Crisis</i> (emergency injection) Do this:		
If above symptoms do not resolve, or if the student experiences sudden, severe worsening of symptoms associated with adrenal insufficiency including: ☐ Unconscious ☐ Vomiting more than once or _____ times ☐ Severe pain in the lower back, abdomen, or legs ☐ Altered mental status (excessively weak or tired, disoriented, confused, or slurred speech). ☐ Other (specify): An emergency dose will be required to prevent adrenal crisis from occurring.		1. Call 911. 2. Call parents/guardian. 3. Administer (name of medication and dose _____mg, intramuscularly into thigh muscle (trained staff only). 4. Stay with the student 5. Complete required documentation 6. Give emergency instructions (if available from healthcare provider) to EMS 7. Other (specify): This is an Emergency Rescue Medication. This needs to be administered ASAP!		
Plan of Action: - Always allow the student to have access to water or electrolyte enriched drink during the school day. - The student should stay away from people with known infections or illness. They may need to change seats in class at times. - Always send student with adult to the office or health room when they are experiencing symptoms or feeling sick. - Notify the nurse and parent immediately if the student is sick or hurt. If parent is unavailable, call 911.				
Special considerations and precautions (regarding school activities, field trips, sports, etc.):				

Adrenal Crisis Rescue Provider Statement & Medication Authorization		
Prescribing healthcare professional to complete (MD, DO, APRN, PA per 53G-9-507)		
Daily maintenance medication name: _____ Dose: _____ Time: _____ ☐ Taken at home ☐ Taken at school. If taken at school: Dose: _____ Time: _____		
YELLOW: minor symptoms <i>stress dose</i> (oral medication)		
Medication	Dose	Instructions
RED: severe symptoms <i>adrenal crisis</i> (emergency injection)		
Medication	Dose	Instructions
Additional Orders:		
☐ I certify that I have prescribed an adrenal crisis rescue medication for the above-named student. <i>The above-named student is under my care. In order to keep this child in optimum health and to help maintain school performance, it is necessary that these orders are to be completed during school hours. This order expires at the end of the current school year or on an earlier date set by the provider: _____.</i>		
Prescriber Name:		Phone:
Prescriber Signature:		Date:
Parent to complete (per 53G-9-507)		
☐ Yes ☐ No I certify my student's healthcare professional has prescribed adrenal insufficiency medication for him/her. ☐ Yes ☐ No I request the school identify and train school employees who are willing to volunteer to receive training to administer an adrenal insufficiency medication. ☐ Yes ☐ No I authorize a trained school employee volunteer to administer the adrenal insufficiency medication.		
Parent Name (print):	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:
I authorize my child to receive specified procedures at school as directed by the healthcare provider and/or agreed upon with the District RN. As the parent/guardian of the above-named student, I authorize District RN(s) and trained, designated unlicensed staff to perform tasks outlined in the Health Plan/Emergency Action Plan. I release, indemnify, and hold harmless the District RN(s) and designated staff from any claims related to health interventions, provided they follow the healthcare provider's written instructions and/or agreed upon within this plan of care. I consent to communication and information sharing between the prescribing provider and District RN(s) as needed for managing my student's condition and administering medication. I understand that the information in this plan will be shared with school staff and EMS as necessary. EMS will be called in emergencies. I will notify District RN(s) of any changes in my child's health status, care, or medication. Parents/guardians and the student are responsible for providing all required supplies, medications, and equipment. I understand that this document is not valid, and no accommodations will be made, until it is signed by all required parties.		
EMS will handle medication administration, until volunteers are identified and trained by the district nurses.		
Parent Signature:		Date:
District Nurse		
☐ Signed by prescriber and parent ☐ Medication is appropriately labeled ☐ Medication log generated		
Person to administer adrenal crisis rescue medication: ☐ School Nurse ☐ Parent ☐ Other specify): _____ Location Medication is kept: _____		
This healthcare plan is to be distributed via PowerSchool or as needed by the front office to "all need to know" staff.		
District Nurse Signature:		Date: