

**Johnson City Schools
Health Services
Adrenal Insufficiency Action Plan**

PARENT/GUARDIAN

Name: _____ Date of Birth: _____ School Year: _____
School: _____ Grade: _____ Teacher/Homeroom: _____
Parent/Guardian: _____ Phone: _____ Email: _____
Address: _____ City/State/Zip: _____
Secondary Contact: _____ Phone: _____

HEALTHCARE PROVIDER - Please complete and sign medical orders below.

Invalid if altered by anyone other than child's provider

SCHEDULE DAILY MEDICATION: ☐ Hydrocortisone ☐ Fludrocortisone Other: _____

Strength: _____ Dosage: _____ Time to be given: _____
Route of Administration: _____
Date started: _____ Date to be discontinued: _____
Purpose of medication: _____

*****Parents please notify school nurse if the student is on "sick-day" regimen.*****

STRESS DOSE/"SICK-DAY"

STRESS/SICK DOSE MEDICATION: ☐ Hydrocortisone ☐ Fludrocortisone Other: _____

Strength: _____ Dosage: _____ Route: _____
List signs/symptoms to give stress/sick dose: _____

**Follow these steps: Ø Contact parent/guardian. If parent cannot be reached, contact secondary contact listed above.
➤After administration, the student begins to display one or more of the severe signs/symptoms follow instructions below.**

SEVERE SIGNS AND SYMPTOMS: EMERGENCY

1. Administer Solu-Cortef: _____ mg, intramuscularly into thigh muscle.
For one or more of the following signs and symptoms or reasons (provider, please list):

2. Activate EMS, call 911.
3. Contact parent/guardian. If parent cannot be reached, contact secondary contact listed above.

Healthcare Provider Name/Title

Healthcare Provider Signature

Date

Phone Number

Fax number

Email

PARENT/GUARDIAN - Please Read and Sign Below

It is understood that any medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. I understand that I am responsible for furnishing all medications. The school nurse has permission to communicate with the healthcare provider regarding this medication and plan of care including, but not limited to, orders, clarification of orders, etc. I understand that the healthcare provider may disclose protected health information in consultation with the school nurses. All information obtained will remain confidential and be available on a need-to-know basis to those individuals who are involved in providing for your child's health and educational needs at school. In consideration of the acceptance of the request to perform this service by any person employed by the Johnson City School System, the undersigned parent or guardian hereby understands and agrees that the Johnson City School System and its personnel shall not be liable for any injury resulting from the reasonable and prudent administration of medication or the reasonable performance of health care procedures, including the administration of medication. I, the undersigned parent or guardian hereby understand and agree that Johnson City Schools and its personnel shall not be liable for any injury resulting from the student's self-administration of the medication, if applicable per health care provider's selection above, while on school property or at a school-related event or activity unless in cases of wanton or willful misconduct. I will notify extra-curricular staff about the health plan and care to be given during after school activities, if applicable. By signing, parent indicates agreement with the individual health plan as described by healthcare provider.

Parent/Guardian Signature

Printed Name

Date

Verified by School Nurse: Initials _____ Date: _____

Reviewed 03/26