



WALL TOWNSHIP PUBLIC SCHOOLS

1620 18th Avenue · PO Box 1199

Wall Township, NJ 07719

DISTRICT HEAD NURSE: Nurse Carrie Penn RN, BSN, CSN

HYDROCORTISONE SODIUM SUCCINATE-Action Plan Emergency Use and Authorization

Dear Parent/Guardian,

You have informed the school nurse that your child experiences adrenal insufficiency. In cooperation with your child's physician, please complete the information below and return it to the school nurse. ***This form is only valid for the current school year.***

Student Name: _____ Grade: _____ School: _____

Date of Birth: _____

Emergency Contact Information

Parent/ Guardian 1: _____ Cell Phone _____ Work Phone _____

Parent/Guardian 2: _____ Cell Phone _____ Work Phone _____

Pediatrician: _____ Phone Number _____

Endocrinologist: _____ Phone Number _____

Preferred Hospital: _____

I consent to the release of information contained in this plan to all staff members who have responsibility for my child and who may need to know this information to maintain my child's health and safety. In the event of a school-sponsored activity or function, I will contact the school nurse in advance to discuss suitable accommodations or arrange for a nurse or trained delegate.

Parent/Guardian Signature

Date

Physician Specific Instructions (check all that apply)

- ☐ If there are questions, the parent or guardian should be called. If additional information is needed, the parent or school nurse should contact the endocrine office
- ☐ Stress dose that needs to be given during illness or injury _____
- ☐ Cortisol Injection that needs to be given when vomiting, unconscious or in an emergency

- ☐ During emergencies, the school should call 911 and/or have trained personnel give the cortisol injection

Physician: This student is capable of and has been instructed in the proper self-administration of medication.

☐ Yes

☐ No

MD Signature/ Stamp

Date

Student Name: _____ Grade: _____ Date of Birth: _____

The above student experiences Adrenal Insufficiency. During stress he/she will need extra cortisol medication (stress dose). If the student is unable to take cortisol by mouth the medication will have to be given by injection.

Stress includes:

- Fever
- Vomiting or illness
- Trauma (such as broken bone or bleeding)

Stress dose by mouth: _____ (Nurse must administer).

Examples of when an injection needs to be given:

- Repeated vomiting or diarrhea
- Unconsciousness (unable to arouse)
- Serious injury (broken bone or surgery)

Stress dose Intramuscular: _____ (Nurse or trained delegate) .

Signs and Symptoms of Not Enough Cortisol (acute adrenal insufficiency)

- | | | |
|--|-------------|-------------------------------|
| • nausea or vomiting | • pale face | • dry tongue/thirst |
| • cold clammy skin | • dizziness | • weakness |
| • fast heart rate | • confusion | • dark circles under the eyes |
| • fast breathing | • weakness | • decreased temperature |
| • severe pains in the stomach, legs and back | | |

Instructions for IM dose:

1. You will need:
 - Hydrocortisone Succinate
 - Needle & Syringe
 - Alcohol Swab
1. Peel the center tab off of the plastic cap
2. Push down hard on the yellow cap to release the liquid (if it is an Act-o-vial)
3. Swirl the vial to mix the solution (if it is an Act-o-vial)
4. Clean the cap with alcohol
 - Insert the needle and inject air into the vial
 - Turn the vial upside down

- Pull back the plunger until you have the full dose of medication
5. Inject into the outside of the mid thigh (or buttocks) and **call 911**

Parent/Guardian Signature

Date

MD Signature/ Stamp

Date

Student Name: _____ Grade: _____ Date of Birth: _____

PARENT PERMISSION FOR DESIGNEE TO ADMINISTER HYDROCORTISONE SODIUM SUCCINATE

In the absence of the school nurse, I **GRANT** permission for a trained delegate to administer my child's hydrocortisone sodium succinate as medically ordered. I acknowledge that Wall Township Public Schools and its employees or agents shall incur no liability as a result of any injury arising from the administration of hydrocortisone sodium to my child. I will indemnify and hold harmless the district and its employees against any claims arising out of the administration of Hydrocortisone Sodium Succinate.

Parent/Guardian Signature

Date

PUPIL SELF-ADMINISTRATION OF HYDROCORTISONE SODIUM SUCCINATE

(only if applicable and approved by the physician)

I, _____ give permission for my child, _____ to self-medicate with _____(medication) as prescribed by _____(doctor) for adrenal insufficiency both on school premises during regular school hours and off-site or after regular school hours when they are participating in field trips or extracurricular activities and the school nurse and his/her designee is not present. My child is capable of self-medication and has been instructed on the proper administration of his/her medication. I acknowledge that the Wall Township Public Schools shall incur no liability as a result of any injury arising from the self-administration of medication by my child and that I indemnify and hold harmless the District and its employees or agents against any claims arising out of self-administration of medication by my child.

Parent's/Guardian's Signature

Date