HEALTH SERVICES
Prosper Independent School District

Physician/Parent Authorization for Adrenal Insufficiency Management at School

*This form to be renewed annually and as changes occur.

Student: ____ DOB: ____/____/____ Grade: _______ Date of Plan: ___/____/____

TO BE COMPLETED BY THE PHYSICIAN:

The parent/guardian of the above named student has notified the school that this student has adrenal insufficiency and may require emergency care including intramuscular corticosteroid injections at school for symptoms of adrenal crisis. Please complete this form based on your examination and knowledge of this student and sign in the space provided.

Diagnosis:____

Activity Restrictions:____

Daily medications for this condition: ____

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Emergency Medications

Risk factors for adrenal crisis include physical stress such as infection, illness, dehydration, or trauma. Symptoms may include:

☐ Severe illness	☐ Fever > 100°F	☐ Shortness of breath	☐ Trauma
☐ Chills	☐ Irregular heartbeat	☐ Sudden confusion	☐ Unconsciousness

☐ Other: ____

For one or more of the checked symptoms above administer:

☐ Solu-Cortef ____________ ml which is ________mg IM. The student should then be promptly evaluated in the nearest emergency room (dial 911).

☐ Other Medication: ___________________________________ Instruction: ____

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PHYSICIAN PERMISSION FOR SELF-CARRY & SELF-ADMINISTRATION

Has this student been trained in the risk factors for and signs/symptoms of adrenal crisis? …………………………….…..……… Yes No

Has the student been trained in the preparation and self-administration of Solu-Cortef?…..………………………………...….. Yes No

Is this student capable of preparing and self-administering the Solu-Cortef? …………….………………………………….…..… Yes No

Does this student need the supervision of a designated adult?…………………………………………………………….…..…… Yes No

Does this student have physician permission to self-administer this medication & to carry it on himself/herself?........................ Yes No

Students approved for self-administration of Solu-Cortef in the school setting, must do so in the presence of a school staff member so that appropriate emergency follow-up care can be provided. Otherwise, Solu-Cortef injections* ***will ONLY be administered by a registered nurse.* *This injectable medication will NOT be given by unlicensed school staff.*

PISD PROCEDURE WHEN SOLU-CORTEF ADMINISTRATION IS INDICATED:

Nurse PRESENT

1. Remain calm.
2. Call for help and direct 911 to be called.
3. RN prepares Solu-Cortef injection according to physician orders.
4. RN immediately administers IM injection.
5. Place student on back, elevate legs, continue to monitor vital signs, and keep warm.
6. Remain with student until EMS arrives.
7. Contact parent/guardian.
8. Send copy of this EAP and student's labeled medication with EMS to Emergency Room.
9. Notify Director of Health Services of the incident.

Nurse NOT PRESENT

1. Remain calm.
2. Call for help and direct 911 to be called.
3. Call partner nurse to assist with emergency.
4. If student is approved for self-administration of Solu-Cortef and is physically/mentally able, student should administer medication immediately. If not, proceed to next step.
5. Place student on back, elevate legs, continue to monitor vital signs, keep warm.
6. Remain with student until EMS arrives.
7. Contact parent/guardian.
8. Send copy of this plan and student's labeled medication with EMS to Emergency Room.
9. Notify Director of Health Services of the incident.

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Additional information / instructions: ____

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Physician Name: ______________________ **Signature**: ______________________ Date:__________

Clinic/facility: ____ Phone: (______)________________

TO BE COMPLETED BY THE PARENT/GUARDIAN --

I, the parent or guardian of ______________________________, agree with his/her physician to allow the **registered nurse (only)** to administer the above prescribed dose of Solu-Cortef IM to my child. 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 or my student is at an off-campus event where a nurse is not present, 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 a copy of the physician orders with the paramedics to the emergency room.

I understand that it is my responsibility to provide the prescribed medications to the school in order for the treatment prescribed by my physician above to be provided by district nurses. I understand that in addition to this form, a PISD Medication Administration Request form must be completed for each medication provided to the school for my child, in accordance with PISD medication guidelines. I will notify the school immediately if the health status of my child changes, I change physicians, or the procedure is canceled or changed in any way. I also give my permission for Prosper ISD nursing staff to contact the physician/healthcare provider for additional clarification of these orders if needed.

Parent's Signature: ____ Date: ________________

FOR SELF-CARRY & SELF-ADMINISTRATION ONLY

I, the parent/guardian of ______________________________ request that he/she be allowed to carry and self-administer the prescribed intramuscular Solu-Cortef in the presence of a PISD staff member when the campus nurse is not available. I understand that my child's emergency medication & related supplies must be stored in a properly labeled container (which includes the prescription label) at all times .I understand that PISD reserves the right to require that this medication be kept in the clinic if, in the school nurse's judgment, the student cannot or will not carry the medication in a safe manner and/or properly self-administer the medication.

My child will keep the Solu-Cortef and necessary supplies for administration in his/her:

☐ Backpack ☐ Purse ☐ Other: ______________ while at school.

Parent's Signature: ____ Date: ________________