HUMBLE ISD HEALTH SERVICES

Adrenal Insufficiency Emergency Action Plan

The student named below has adrenal insufficiency, a disorder in which the adrenal glands do not make enough cortisol. Cortisol is essential in the management of stress such as illness and injury, and a person can become very ill or go into shock without cortisol. Adrenal insufficiency is easily managed with strict adherence to a treatment plan.

Student Name:____

Birthdate: ___/___/______ Grade:______ School:_________________________ ID:_____________

Routine cortisol doses: Morning dose:___:___a.m. _________mg PO

Afternoon dose:___:___a.m./p.m. ___________mg PO

Evening dose:___:___p.m. __________mg PO

For **MINOR illness or stress** checked below, administer cortisol by mouth:________mg PO

____Fever≥100°F ____Suspected Fracture ____Mild Vomiting (one time)

Other:____

For **SEVERE illness or stress** checked below, the **licensed medical professional administers** IM cortisol and notifies parent/guardian then calls 911. In the absence of a licensed medical professional, unlicensed staff should call 911 then notify parent/guardian (do not inject cortisol).

Cortisol injection strength:__________mg /ml Dose:___________ml IM

____Major injury/trauma/compound fracture ____Student is confused or unresponsive

____Severe dehydration ____ Continuous Vomiting (more than once)

Other:____

By signing below, I certify that I consent to the treatment plan outlined above, and I consent to the campus nurse/staff contacting the physician listed below for consultation.

_______________________________________ Parent/Guardian Name	(_____)______-_____________ Parent/Guardian Phone No.
_______________________________________ Parent/Guardian Signature	_________________________ Date
_______________________________________ Healthcare Provider with Prescriptive Authority Name	(_____)______-_____________ Healthcare Provider Phone No.
_______________________________________ Healthcare Provider Signature	_________________________ Date

Attach Humble ISD medication authorization form

Humble Independent School District Health Services

Authorization and Permission for Administration of Medication

☐ In eSchool
Nurse Initial_____
Expiration Date
____

Guidelines for acceptance and administration of medications in Humble ISD are available from the campus nurse.

Students Name____ **DOB**__________________
Last First MI

PARENT/GUARDIAN SECTION

______________ __ ____ ________________ _

Medication name **Strength** **Dosage** **Route** **Time**

Start Date____________________ Allergies____

Special Instructions/Duration____

Condition for which drug is to be given____

Medications currently taken at home____

Note: Non-prescription medications taken more than 4 times in a month and prescription PRN medication will require a physician's order (signature is required) indicating maximum dosage allowed per month.

PARENT: PLEASE SIGN AT THE BOTTOM OF THE MEDICATION FORM

PHYSICIAN'S SECTION: PLEASE WRITE ORDER FOR SCHOOL ADMINISTRATION

Parent approval for release of information indicated below. Prescription medication given more than 10 days, non-prescription medication given more than 4 times in a month, or in excess of recommended dosage on the container and all prescription PRN medications require a physician's order.

______________ __ ____ ________________ _

Medication name **Strength** **Dosage** **Route** **Time**

Start Date____________________ Allergies____

Special Instructions/Duration____

Condition for which drug is to be given____

Medications currently taken at home____

Physician's name (print)_____________________ **Physician's signature**________________________

Phone number__________________ **Fax number**___________________ **Date**__________________

I request the above named student be given the medication at school by qualified staff, according to the prescription or non-prescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the physician as needed and that medication information may be shared with school personnel who need to know. I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication.
Completion of this form acknowledges your review of and agreement to follow all district medication guidelines.

Parent's Signature _____________________________ **Date**___________
Daytime Phone_____________________________ Alternate phone _________________________

Humble Independent School District Health Services

Authorization for Release of Medical Records

Student____ DOB______________ Date_______________

Campus____ Grade_____________

I grant permission for the release of medical information and physician recommendations as it pertains to the student's accommodations which will allow for participation in the educational process with minimal disruption.

Information requested____

____

____

From: (Physician Name & Address) To: (School Nurse)

____ ________________________________

____ ________________________________

____ ________________________________

____ ________________________________

____ ________________________________

Signature of Parent/Guardian, Date
(Student if 18 years or older)

The mission of Humble ISD Health Services is to enhance the health and well being of the students, staff, and community thus supporting the education of all students through maximizing their educational time.

Humble Independent School District Health Services

Adrenal Insufficiency Health History

Student Name:________________________________
Student ID:____________________ Date of Birth: ________________
Parent/Guardian:____________________ Home Phone:________________
Cell Phone:____________________ Work Phone:________________

1. **Does your child have a diagnosis of adrenal insufficiency from a healthcare provider:** ☐ **No** ☐ **Yes**
   Managing physician:____________________ Phone:____________________

2. **History of Current Status:**

a. What are your child's triggers:

☐ Mild illness ☐ Anxiety/stress
☐ Infections ☐ Trauma/major injury
☐ Fever ≥100.0 ☐ Mild injury
☐ Dehydration ☐ Other__________
☐ ____________________

b. Age of student when adrenal insufficiency first diagnosed: __________

c. Date of last adrenal crisis episode:________________

c. How often does your child take emergency medication:
☐ Rarely ☐ Occasionally ☐ Monthly ☐ Weekly
☐ My child does not have/has not been prescribed emergency medications

d. Symptoms:________________________________

e. Ever hospitalized due to adrenal insufficiency: ☐Yes ☐ No
If yes, explain:________________________________

f. Are the number of episodes: ☐Same ☐Better ☐Worse

3. **Trigger and Symptoms:**
   a. What are the early signs and symptoms of your student's adrenal crisis episode? *(Be specific; include things the student might say)* ____________________
   b. How does your child communicate his/her symptoms? ____________________
   c. How quickly do symptoms appear after trigger? Within: ______ secs _____ mins _____ hrs _____ days
   d. Please check the symptoms your child has experienced in the past:

General	Abdominal	Mouth/Lungs	Head	Heart
☐ Weakness	☐ Nausea	☐ Loss of appetite	☐ Headache	☐ Increased pulse
☐ Fatigue	☐ Vomiting	☐ Dehydration	☐ Fever	☐ Loss of consciousness
☐ Confusion	☐ Abdominal pain	☐ Fast respiratory rate	☐ Sweating	
☐ Dizzy or lightheaded	☐ Flank pain			
☐ Slow movements				

4. **Treatment:**
   a. How is adrenal insufficiency being treated? ____________________
   b. What medication is the student taking (both daily and emergency)?____________________
   c. How effective is the student's response to treatment? ____________________
   d. Has there ever been an emergency room visit? ☐ No ☐ Yes, explain:____________________
   e. Was the student admitted to the hospital? ☐ No ☐ Yes, explain:____________________
   f. Has your healthcare provider provided you with a prescription for medication? ☐ No ☐ Yes
   g. Have you used the treatment or medication? ☐ No ☐ Yes
   h. Please describe any side effects or problems your child had in using the suggested treatment: ________________

5. **Self Care:**
   a. Is your student able to recognize and monitor their adrenal crisis symptoms? ☐ No ☐ Yes
   b. Does your student:
      1. Know what triggers to avoid………………………….............................. ☐ No ☐ Yes
      2. Communicate early symptoms………………………………….......... ☐ No ☐ Yes
      3. Tell an adult immediately when symptoms occur………………………… ☐ No ☐ Yes
      4. Wear a medical alert bracelet, necklace, watchband……………………… ☐ No ☐ Yes
      5. Tell peers and adults about their condition ………………………………. .☐ No ☐ Yes
   c. Does your student know how to use their emergency medication? ☐ No ☐ Yes
   d. Has your child ever administered their own emergency medication? ☐ No ☐ Yes

6. **Family/Home**
   a. How do you feel that the whole family is coping with your student's condition? ______________________________
   b. Does your child carry medication in the event of a crisis episode? ☐ No ☐ Yes
   c. Has your child ever had to be injected with emergency cortisol/medication? ☐ No ☐ Yes
   d. Do you feel that your child needs assistance in coping with his/her condition? ☐ No ☐ Yes

7. **General Health:**
   a. How is your child's general health other than having adrenal insufficiency? ______________________________
   b. Does your child have other health conditions? ______________________________
   c. Please add anything else you would like the school to know about your child's health: ______________________
      ____

8. NOTES:
   ____
   ____
   ____
   ____
   ____

Parent/Guardian Signature:______________________________ **Date:** ______________________

Reviewed by:______________________ **Campus:**______________ **Date:** ______________________

Health Office Use

Student Comments:

What do you want us know about how you handle your health issues? ______________________________

How can the staff assist you before, during and after an adrenal crisis? ______________________________

Do you understand what the nurse and teacher will be doing to help you when you have an episode?

____