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, (Student if 18 years or older)

Date

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.