**Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The above student is cortisol dependent because of **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** diagnosis. This condition can result in acute adrenal crisis that can be a life threatening state caused by insufficient levels of cortisol, which is a hormone produced and released by the adrenal gland. Some students may require oral hormone replacement on a daily basis. The student can go into shock requiring emergency treatment if they do not receive this medication.

|  |  |  |  |
| --- | --- | --- | --- |
| **Indication** | **Name of medication** | **Dose** | **Time** |
| **DAILY:** Maintenance cortisol replacement  |  |  |  |

**Risk factors for acute adrenal crisis include physical stress such as infection, illness, dehydration, or trauma.** An intramuscular injection (IM) of Solu-Cortef (an injectable corticosteroid) may need to be given if the student is unable to take cortisol replacement by mouth.

**Signs and symptoms of not enough cortisol (acute adrenal crisis) include**:

• Nausea or vomiting • Dark circles under the eyes • Signs of dehydration

• Dizziness • Severe pain in stomach, legs and back • Decrease temperature

• Cold, clammy skin • Weakness • Fast heart rate or breathing

• Confusion • Pale Face

**Please Indicate Medications to Administer for the Following Situations**:

|  |  |
| --- | --- |
| **Mild or Moderate Illness or Injury, such as:** | **Administer the following stress dose:** **(Name of medication/dose/time/route)** |
| * Fever greater than 101
 |  |
| * Mild vomiting or diarrhea (1 time)
 |  |
| * Illness such as throat or ear infection, pneumonia, flu
 |  |
| * Mild injury such as minor bleeding or sprain
 |  |
| * Other
 |  |
|  |  |
| **Major Illness or Injury, such as:** | **Administer the following IM Cortisol Injection****(Name of medication/dose/time/route) and** * **Call 911 and Parents/Legal Guardian:**
 |
| * Fever greater than 102
 |  |
| * Repeated vomiting or diarrhea (two or more times)
 |  |
| * Unconsciousness (passed out or unable to arouse)
 |  |
| * Serious injury such as severe bleeding, broken bone, trauma or surgery
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|  |  |

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| --- |
| **Endocrinologist/Healthcare Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Endocrinologist/Healthcare Provider Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Office Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****(\*This order is valid for one year from signature date and must be renewed yearly.)**  |

I, Parent/Legal Guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree with their endocrinologist or healthcare provider and allow the nurse and/or trained staff to administer the above prescribed dose of medications as detailed above to my student.

I understand that the TSBVI nurse will administer Solu-Cortef IM, unless other arrangements or training have taken place. In a situation where my child is off campus, 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 the physician orders with the paramedics to the emergency room.

Parent/Legal Guardian accepts responsibility for the following:

1. Providing Solu-Cortef (un-expired vial) to the school nurse upon student enrolling in TSBVI. Medication must be properly labeled from the pharmacy.

2. Promptly communicating changes in the student’s physical condition with the school nurse and/or school staff.

3. Provide updated Action Plan yearly and for changes in emergency doses signed by the endocrinologist or healthcare provider.

4. Provide and keep current emergency numbers to be used for contacting parent in the case of emergency.

5. Will discuss with the school nurse side effects observed from previous Solu-Cortef IM Injections, if any.

**Parent/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Legal Guardian Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**School Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**School Nurse Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TSBVI Health Center Phone Number**: (512) 206-9136

**TSBVI Health Center Fax**: (512) 206-9445