

**PLANO INDEPENDENT SCHOOL DISTRICT
ADRENAL CRISIS ACTION PLAN
Administered ONLY BY SCHOOL NURSE**

Student's Name: _____
Date of Birth: _____ Grade _____ SCHOOL _____

This is a letter for our patient _____ who has _____ diagnosis. This condition can result in acute 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. An intramuscular injection (IM) of Solu-Cortef (an injectable corticosteroid) must be given as soon as possible to increase the chance for a quick recovery.

Risk factors for **adrenal crisis** include physical stress such as infection, illness, dehydration, or trauma. In situations where one or more of the risk factors are present IM Solu-Cortef is required.

For one or more of the **checked** symptoms below administer Solu-Cortef _____ ml which is _____ mg IM. This injection should be given immediately and the patient should be promptly evaluated by a physician in the nearest emergency room (dial 911).

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| <input type="checkbox"/> severe illness | <input type="checkbox"/> chills |
| <input type="checkbox"/> fever of ≥ 100 degrees F | <input type="checkbox"/> irregular heart beat |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> sudden confusion/unconsciousness |
| <input type="checkbox"/> trauma | <input type="checkbox"/> other _____ |

I, the parent or guardian of _____ (student's name) agree with his/her physician to allow the **registered nurse (only)** to administer the above prescribed dose of Solu-Cortef IM to my son/daughter _____ (student's name). 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, 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 or Guardian accepts responsibility for the following:**
1. Providing Solu-Cortef (un-expired vial) to the school nurse upon student enrolling in Plano ISD. Medication must be properly labeled from the pharmacy.
 2. Promptly communicating changes in the students 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 physician.
 4. Provide and keep current emergency numbers to be used for contacting parent in case of emergency.
 5. Will discuss with the school nurse side effects observed from previous Solu-Cortef IM injections (if any).

In exchange for District agreeing to the administration of the Adrenal Crisis Action Plan, as outlined herein, I knowingly, freely and voluntarily, for my child, myself, my heirs, personal representatives and assigns, indemnify, hold harmless, release and discharge the District, its governing board, agents, employees, and officers, from any and all claims, demands, liabilities, actions, judgments, expenses (including attorneys' fees and costs of defense), and executions which may be made by reason of any personal injury to my child (including, but not limited to, serious bodily injury or death) caused by any act, neglect, default, or omission of any person, firm, or corporation, directly or indirectly associated with the administration of the Adrenal Crisis Action Plan, including but not limited to, the negligence, whether by act or omission, of the District and/or its representatives, agents or employees and/or the strict liability of the District and/or its representatives, agents or employees.

ACTION FOR MAJOR REACTION:

1. Give above prescribed dose of IM Solu-Cortef
2. Call 911
3. Call parent(s) or guardian(s): Contact Number(s)

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**DO NOT HESITATE TO ADMINISTER IM MEDICATION OR CALL EMERGENCY MEDICAL SERVICES
EVEN IF PARENTS CANNOT BE REACHED.**

BY SIGNING BELOW I CERTIFY THAT I HAVE READ THE INFORMATION ABOVE.

Parent/Guardian's Signature

Doctor's Signature

Date

Date

Doctor's Phone No.