Williamson County Schools
Adrenal Crisis Action Plan
(This form must be signed by a Physician)

Student Name____ Date of Birth______________________

School____ Grade_________ School Year________________________

Diagnosis____

PHYSICIAN'S ORDER–MEDICATIONS FOR TREATMENT OF ADRENAL INSUFFIENCY (include daily/stress/crisis if needed)

Name of Medication	Strength and Dose to be Given	When to Administer at School (i.e., daily, stress, emergency)

EMERGENCY ACTION PLAN

1. Contact School Nurse at ____________________.
2. Administer medications as indicated above.
3. **CALL 911** after emergency injection or if in doubt.
4. Stay with student and monitor.
5. Notify parent or emergency contact.

The most serious complication of adrenal insufficiency is adrenal crisis. If not treated right away, adrenal crisis can cause death. An injection of corticosteroid medicine can be life-saving in adrenal crisis. Notify 911/clinic immediately for any of the above symptoms in this student. Nurse will notify parent.

Mild symptoms	**Oral Stress Dose**
• fever • vomiting or diarrhea • other____________________________________	1. Administer __________________________________. 2. Call Parent/guardian
For one or more Emergency Symptoms:	**Emergency Administration – Corticosteroid Injection**
• Sudden, severe pain in lower back, abdomen or legs • Vomiting and diarrhea • Weakness • Confusion • Loss of consciousness	1. Administer _____________________ immediately, turn the student to his/her side, and monitor breathing. 2. Call 9-1-1 3. Call Parents/guardians 4. Document your actions

Training: ☐ I, the supervising physician, authorize the school nurse to provide training to other school personnel in the administration of emergency hydrocortisone.

Physician's Signature____ **Date**_________________________

Physician's Name (Print)____ **Phone**________________________

PARENT/GUARDIAN'S AUTHORIZATION (Required)

I give permission for the medication(s) listed to be administered in school by the nurse or other trained personnel. I consent to communication between the school nurse and prescribing health care provider or clinic to discuss disease management and administration of the medication. The undersigned parent/guardian hereby agrees to exempt and release the school district and its directors, officers, employees, volunteers, and agents from any and all liability, claims, demands, or actions whatsoever arising out of any damage, loss, or injury that my student or I/we might sustain or which they now have or may hereafter have arising out of the administration of this medication.

Parent/Guardian's Signature____ **Date**_________________________

Parent/Guardian's Name (Print)____ **Phone**________________________