BLUE SPRINGS SCHOOL DISTRICT
ADRENAL INSUFFICIENCY
ACTION PLAN

Student Name: _____ **DOB:** _____ **Grade:** _____

Parent/Guardian Name: _____**Parent/Guardian Phone #:** _____

Parent/Guardian Name: _____**Parent/Guardian Phone#:** _____

Emergency Contact Name: _____**Emergency Contact Phone #:** _____

HEALTH CARE PROVIDER: Please Complete and Sign Medical Orders Below

Risk factors for acute adrenal crisis include physical stress such as infection, illness, dehydration, or trauma.

MILD SIGNS AND SYMPTOMS:

If student displays one or more of the following **mild** signs and symptoms (provider, please list): _____

_____

Follow these steps:

1. Contact parent/guardian. If parent cannot be reached, contact emergency contact(s).
2. Administer hydrocortisone: _____mg, by mouth.
3. If, after receiving oral hydrocortisone, the student begins to display one or more of the **severe** signs and symptoms below, follow steps below.

SEVERE SIGNS AND SYMPTOMS:

If student displays one or more of the following **severe** signs and symptoms (provider, please list):_____

_____

Follow these steps:

1. Administer Solu-Cortef or _____: _____mg, intramuscularly (into thigh muscle if self-injected).
2. Activate EMS.
3. Contact parent/guardian. If parent cannot be reached, contact emergency contact(s).
4. Contact Healthcare Provider.

_____ _____ _____

Healthcare Provider Name/Title **Healthcare Provider Signature** **Date**

_____ _____ _____

Phone Number **Fax Number** **Email**

I give my permission to the school, school nurse, and other designated and trained staff member(s) to perform and carry out the steps as outlined by this Plan for my child, and I acknowledge that I may receive a copy of this signed plan. I also consent to the release of the information contained in this plan to all staff and other adults who have contact with my child and who may need to know this information to maintain my child's health and safety. I will notify extra-curricular staff about health plan and care to be given during after school activities. I give my permission for the school nurse to contact my child's healthcare provider(s) regarding the above condition.

_____ _____ _____

Parent/Guardian Signature **Printed Name** **Date**

I have reviewed this order, completed the Acute Adrenal Insufficiency Action Plan, and shared with pertinent school personnel.

_____ _____ _____

School Nurse Signature **Printed Name** **Date**