

School Year _____



ADRENAL CRISIS MEDICAL ACTION PLAN

Student Name: _____	DOB: _____
School: _____	_____
Parent/Guardian Name: _____	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/guardian cannot be reached, contact emergency contact(s).
2. Administer hydrocortisone: _____ mg, by mouth.
3. If, after receiving hydrocortisone, the student begins to display one or more of the **severe** signs and symptoms below, please 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: _____ mg, intramuscularly (into thigh muscle if self-injected).
2. Activate 911.
3. Contact parent/guardian. If parent/guardian cannot be reached, contact emergency contact(s).

Healthcare Provider Name/Title

Healthcare Provider Signature

Date

Phone Number

Fax Number

I give my permission to the school, school nurse, licensed/unlicensed assistive personnel, and other designated staff member(s) to perform and carry out the care tasks as outlined by this Acute Adrenal Crisis Action Plan for my child. I also consent to the release of the information contained in this plan to all staff and other adults who have custodial care of 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



Waverly Community Schools Medication Administration Authorization Form

Michigan State Law requires that school staff administering medications must have written orders from the physician/licensed prescriber and written authorization from the parent/guardian. Parents are urged to give medication at home on a schedule outside of school hours, if possible. If it is necessary that medication be provided during school hours, these regulations must be followed:

- All prescription medications must have a written order from a physician or other licensed prescriber and must be renewed every year or with any changes. Any medication that is a controlled substance must be renewed every 30 days or with any changes.
- All medication must be brought to school in the original pharmacy or OTC container labeled with the name of the student, medication, strength, dosage, route, and time(s) to be given. The parent/guardian is expected to deliver the medication to the school. Students are not allowed to bring their own medication to school.
- Medications and related equipment/supplies, as ordered, must be provided to the school by parent/guardian as needed.
- A separate authorization form must be completed for each medication that will be administered throughout the school day.

STUDENT'S NAME: _____ **DATE OF BIRTH:** _____

SCHOOL: _____

TO BE COMPLETED BY THE PHYSICIAN:

Medication Name	Dosage	Route	Frequency and Time

Form of Medication: <input type="checkbox"/> Tablet/Capsule <input type="checkbox"/> Liquid <input type="checkbox"/> Inhaler <input type="checkbox"/> Injection <input type="checkbox"/> Other:	
Diagnosis:	
Special instructions/storage requirements:	
Restrictions and/or important side effects:	
Is student able to self-carry this medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Order start date:	Order end date:
<i>(If no end date is indicated, medication orders will expire at the end of the current school year).</i>	
Prescriber signature:	Date:
Printed Name:	NPI#:
Address:	
Phone:	Fax:

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby give permission for school personnel to exchange this information as necessary, administer medication, and provide care for my child, and to contact the child's physician when deemed necessary. I assume full responsibility for providing the school with all prescribed medications as outlined above and any required medical equipment or devices.

I understand and agree that, pursuant to Public Act 157 of 1971 (MCL 380.1178), when school personnel administer medication to my child in accordance with this authorization, I shall not hold the school district, its employees, or agents liable in any criminal action or for civil damages resulting from the administration of such medication, except as provided by law.

All medications must be picked up by a parent or legal guardian within one (1) week following the student's last day of classes. Any medication not collected within this timeframe will be disposed of in accordance with applicable laws and school district policy.

Signature:	Relationship:	Date:
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Please return completed form to the school office or to the District Nurse