Wall Township Public Schools

1620 18th Avenue Wall, NJ 07719

HYDROCORTISONE SODIUM SUCCINATE-Action Plan
Emergency Use and Authorization

Dear Parent/Guardian,

You have informed the school nurse that your child experiences adrenal insufficiency. In cooperation with your child's physician, please complete the following information below and return it to the school nurse. ***This form is only valid for the current school year***

Student Name:_____ Grade:_____ Date of Birth: _____
School: _____

Emergency Contact Information
Parent/ Guardian : _____Cell Phone_____ Work Phone_____
Parent/Guardian 2: _____ Cell Phone_____ Work Phone_____

Pediatrician: _____ Phone Number_____
Endocrinologist:_____ Phone Number_____
Preferred Hospital:_____

I consent to the release of information contained in this plan to all staff members who have responsibility for my child and who may need to know this information to maintain my child's health and safety. In the event of a school sponsored activity or function, I will contact the school nurse in advance to discuss suitable accommodations or arrange for a nurse or trained delegate.

_____ _____
Parent/Guardian Signature Date

Physician Specific Instructions (check all that apply)

- ☐ If there are questions the parent or guardian should be called. If additional information is needed the parent or school nurse should contact the endocrine office
- ☐ Stress dose that needs to be given during illness or injury_____
- ☐ Cortisol Injection that needs to be given when vomiting, unconscious or in an emergency_____
- ☐ During emergency situations the school should call 911 and/or have trained personnel give the cortisol injection

Physician: This student is capable of and has been instructed in the proper self-administration of medication.

- ☐ Yes
- ☐ No

_____ _____
MD Signature/ Stamp Date

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Student:_____ Grade: _____ Date of Birth: _____

The above student experiences Adrenal Insufficiency. During stress he/she will need extra cortisol medication (stress dose). If the student is unable to take cortisol by mouth the medication will have to be given by injection.

Stress includes:

- Fever
- Vomiting or illness
- Trauma (such as broken bone or bleeding)

Stress dose by mouth:_____ (Only nurse to administer)

Examples of when an injection needs to be given:

- Repeated vomiting or diarrhea
- Unconsciousness (unable to arouse)
- Serious injury (broken bone or surgery)

Stress dose Intramuscular:_____ (Nurse or trained delegate)

Signs and Symptoms of not enough cortisol (acute adrenal insufficiency)

- nausea or vomiting
- cold clammy skin
- fast heart rate
- fast breathing
- weakness
- Pale face
- dizziness
- confusion
- severe pains in the stomach, legs and back
- dry tongue/thirst
- weakness
- dark Circles under the eyes
- decreased temperature

Instructions for IM dose:

1. You will need:
    - Hydrocortisone Succinate
    - Needle & Syringe
    - Alcohol Swab
1. Peel the center tab off of the plastic cap
2. Push down hard on the yellow cap to release the liquid (if it is an Act-o-vial)
3. Swirl the vial to mix the solution (if it is an Act-o-vial)
4. Clean the cap with alcohol
    - Insert the needle and inject air into the vial
    - Turn the vial upside down
    - Pull back the plunger until you have the full dose of medication
5. Inject into the outside of the mid thigh (or buttocks)
6. Call 9-1-1

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HYDROCORTISONE SODIUM SUCCINATE- Action Plan(cont.)

_____ _____

Parent/Guardian Signature Date

_____ _____

MD Signature/ Stamp Date

PARENT PERMISSION FOR DESIGNEE TO ADMINISTER HYDROCORTISONE SODIUM SUCCINATE

In the absence of the school nurse, I **GRANT** permission for a trained delegate to administer my child's hydrocortisone sodium succinate as medically ordered. I acknowledge that Wall Township Public Schools and its employees or agents shall incur no liability as a result of any injury arising from the administration of hydrocortisone sodium to my child. I will indemnify and hold harmless the district and its employees against any claims arising out of the administration of Hydrocortisone Sodium Succinate.

_____ _____

Parent/Guardian Signature Date

PUPIL SELF-ADMINISTRATION OF HYDROCORTISONE SODIUM SUCCINATE
(only if applicable and approved by the physician)

I, _____ give permission for my child,_____ to self-medicate with _____(medication) as prescribed by _____(doctor) for adrenal insufficiency both on school premises during regular school hours and off-site or after regular school hours when they are participating in field trips or extracurricular activities and the school nurse and his/her designee is not present. My child is capable of self-medication and has been instructed on the proper administration of his/her medication. I acknowledge that the Wall Township Public Schools shall incur no liability as a result of any injury arising from the self-administration of medication by my child and that I indemnify and hold harmless the District and its employees or agents against any claims arising out of self-administration of medication by my child.

_____ _____

Parent's/Guardian's Signature Date