 Student name: _____ DOB: _____

Adrenal crisis rescue authorization
Emergency action plan (EAP)/medication order
In accordance with UCA 53G-9-507
Utah Department of Health and Human Services/Utah State Board of Education

Student information

School year:

Student name:	Date of birth:	Grade:	School:
Parent name:	Phone:		Email:
Physician name:	Phone:		Fax or email:
School nurse name:	School phone:		Fax or email:
Medical diagnosis(es):			Age at diagnosis:

Adrenal crisis emergency action plan

Students with adrenal insufficiency conditions may also need a separate Section 504 plan in plan to provide accommodations necessary to access their education.

Medical history:

Yellow: minor symptoms need *stress dose* If you see this:	Actions for *stress dose* (oral medication) Do this:
If the student is experiencing any minor signs or symptoms below: ☐ Fever higher than ____. ☐ Vomiting once, or ____ times. ☐ Serious injury (broken bones, head injury, auto or bike accident) ☐ Other (specify):	1. Call parent/guardian 2. Give ____ tablet(s) of _____ (hydrocortisone) (5 mg tablets). 3. Offer small sips of water, sports drink, or clear carbonated beverage until a parent arrives if the medication was given due to vomiting. 4. Complete required documentation 5. Other (specify):
Red: severe symptoms are an *adrenal crisis* **If you see this:**	**Actions for *adrenal crisis* (emergency injection)** **Do this:**
If above symptoms do not resolve, or if the student experiences sudden, severe worsening of symptoms associated with adrenal insufficiency including: ☐ Unconscious ☐Vomiting more than once or ____ times ☐ Severe pain in the lower back, abdomen, or legs ☐ Altered mental status (excessively weak or tired, disoriented, confused, or slurred speech). ☐ Other (specify): **An emergency dose will be required to prevent adrenal crisis from occurring.**	1. Call 911. 2. Call parents/guardian. 3. Administer (name of medication and dose) _____ mg, intramuscularly into thigh muscle (trained staff only). 4. Stay with the student 5. Complete required documentation 6. Give emergency instructions (if available from healthcare provider) to EMS 7. Other (specify): **This needs to be administered ASAP, it is an emergency rescue medication.**

Plan of Action:

- Always allow the student to have access to water or electrolyte enriched drink during the school day.
- The student should stay away from people with known infections or illness. They may need to change seats in class at times.
- Always send student with adult to the office or health room when they are experiencing symptoms or feeling sick.
- Notify the nurse and parent immediately if the student is sick or hurt. If parent is unavailable, call 911.

Special considerations and precautions (regarding school activities, field trips, sports, etc.):

 Student name: _____ DOB: _____

Adrenal crisis rescue medication authorization

Prescribing healthcare professional to complete (MD, DO, APRN, PA per 53G-9-507)

Daily maintenance medication name: _____ Dose: _____ Time: _____
☐ Taken at home
☐ Taken at school. If taken at school: Dose:_____ Time:_____

Yellow: minor symptoms *stress dose (*oral medication*)*

Name of medication	Dose	Instructions

Red: severe symptoms *adrenal crisis* (emergency injection)

Name of medication	Dose	Instructions

Additional orders:

☐ I certify that I have prescribed an adrenal crisis rescue medication for the above-named student.

Prescriber name:	Phone:
Prescriber signature:	Date:

Parent to complete (per 53G-9-507)

☐ Yes ☐ No I certify my student's healthcare professional has prescribed adrenal insufficiency medication for him/her.
☐ Yes ☐ No I request the school identify and train school employees who are willing to volunteer to receive training to administer an adrenal insufficiency medication.
☐ Yes ☐ No I authorize a trained school employee volunteer to administer the adrenal insufficiency medication.

Parent name (print):	Signature:	Date:
Emergency contact name:	Relationship:	Phone:

I consent to the release of the information contained in this emergency action plan to all school staff members and other adults who have responsibility for my student and who may need to know this information to maintain my student's health and safety. I also give permission to the school nurse to collaborate with my student's healthcare provider.

Parent signature:	Date:

School nurse

☐ Signed by prescriber and parent ☐ Medication is appropriately labeled ☐ Medication log generated

Person to administer adrenal crisis rescue medication:
☐ School nurse ☐ parent ☐ school volunteer (specify): ☐ other (specify):
Attach volunteer(s) training documentation

Adrenal crisis rescue medication is kept:
☐ Classroom ☐ Health office ☐Front office ☐ Other (specify):

Adrenal crisis EAP distributed to "need-to-know" staff:
☐Teacher(s) ☐Front office/administration ☐Transportation ☐Other (specify):

School nurse signature:	Date: