MARSHALL COUNTY SCHOOLS ADRENAL CRISIS ACTION PLAN AND MEDICATION ORDERS

SCHOOL YEAR: _____ Student has □ 504; □ IEP

PARENT/GUARDIAN -- complete the top portion of form and sign at the bottom.

Copies of Plan provided to: ___ Teachers ___ Parent ___ Other

Name: _____ Date of Birth: _____

Grade: _____ Teacher/Homeroom: _____

Parent/Guardian: _____ Secondary Contact: _____

Parent Email: _____ Secondary Contact Phone: _____

Parent Phone: _____ Other Phone Number: _____

Health Care Provider: _____ Phone: _____

Fax: _____

HEALTH CARE PROVIDER -- complete all items, SIGN and DATE completed form.

DAILY SCHEDULED MEDICINES FOR SCHOOL DAY – NO CURRENT SYMPTOMS

□ **Student requires medication daily at school:**

• Medication Name: _____

• Medication Dose: _____

• Medication Route: _____

• Time medication is to be taken at school: _____

□ **Student does NOT require medication daily at school.**

ORAL STRESS DOSE - FOR MILD SYMPTOMS

□ **Student may need an ORAL stress dose at school for these symptoms – mark all that apply:**

□ Fever > 100.6

□ Vomiting or diarrhea

□ Broken Bones or Serious Injury

□ Other _____

□ **No oral stress dose is ordered for this student.**

Oral Stress Dose: Medication Name: _____ Medication Dose: _____

Next Steps:

• Call Parents (see numbers above).

INJECTABLE STRESS DOSE - FOR SEVERE SYMPTOMS – EMERGENCY SITUATION

□ **Student may need an INJECTED stress dose at school for these emergency symptoms – mark all that apply:**

□ Looks “bad” (pale, sweaty, breathing rapidly)

□ Weakness

□ Lethargy

□ Unable to respond normally

□ Loss of consciousness

□ Vomiting 30 minutes after oral stress dose is given

□ Other: _____

□ **No injected stress dose is ordered for this student.**

Emergency Injectable Stress Dose:

Medication Name: _____ Medication Dose: _____

Medication Route: _____

Next Steps:

• Call a Code Blue to activate the First Responder Team.

• Call 911.

• Call Parents (see numbers above).

School personnel should NOT drive student to hospital.

_____ _____

HEALTH CARE PROVIDER SIGNATURE PRINT PROVIDER’S NAME

_____ _____

PHONE DATE

It is understood that any medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. I understand that I am responsible for furnishing all medications. The school nurse has permission to communicate with the healthcare provider regarding this medication and plan of care including, but not limited to, orders, clarification of orders, etc. I understand that the health care provider may disclose protected health information in consultation with the school nurses. All information obtained will remain confidential and be available on a need-to-know basis to those individuals who are involved in providing for your child's health and educational needs at school. In consideration of the acceptance of the request to perform this service by any person employed by the Marshall County School System, the undersigned parent or guardian hereby understands and agrees that the Marshall County School System and its personnel shall not be liable for any injury resulting from the reasonable and prudent administration of medication or the reasonable performance of health care procedures, including the administration of medication.

By signing, parent indicates agreement with the plan of action as described by health care provider.

_____ _____

PARENT SIGNATURE DATE

_____ _____

SCHOOL NURSE SIGNATURE DATE