Adrenal Insufficiency 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

Picture

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 may need a separate Section 504 plan to provide necessary accommodations for accessing their education.

Medical history:

Yellow: Minor Symptoms - ***Stress Dose*** **If you see this:**	Actions for ***Stress Dose*** **Do this:**
If the student is experiencing any minor signs or symptoms below: ☐ Fever higher than ____. ☐ Vomiting once, or ____ times. ☐ Serious injury (e.g., broken bones, head injury, auto or bike accident). ☐ Other (specify):	1. Call parent/guardian. 2. Give ____ tablet(s) of _____ (hydrocortisone) (___mg tablets). ***GT__ or Oral__*** 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 - *Adrenal Crisis* **If you see this:**	**Actions for *Adrenal Crisis* (Emergency Injection) Do this:**
If the above symptoms do not resolve, or if the student experiences sudden, severe worsening of symptoms associated with adrenal insufficiency, including: ☐ Unconsciousness. ☐ Vomiting more than once or ____ times. ☐ Severe pain in the lower back, abdomen, or legs. ☐ Altered mental status (e.g., excessive weakness or tiredness, disorientation, confusion, or slurred speech). ☐ Other (specify): Do this: An emergency dose will be required to prevent adrenal crisis from occurring.	1. Call 911. 2. Call parents/guardian. 3. Administer injectable hydrocortisone _____mg, intramuscularly into the 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): Administer medication ASAP; it is an emergency rescue medication.

Plan of Action:

- Always allow the student to have access to water or an electrolyte-enriched drink during the school day.
- The student should avoid contact with people who have known infections or illnesses. They may need to change seats in class as necessary.
- Always send the student with an adult to the office or health room if they have symptoms or feeling unwell.
- Notify the nurse and parent immediately if the student is sick or injured. If parent is unavailable, call 911.

Special considerations and precautions (for School Activities, Field Trips, Sports, etc.):

Student name: _____ Birthdate: _____

Medication Authorization for Adrenal Crisis Rescue

Prescribing Healthcare Professional to Complete (MD, DO, APRN, PA as 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 that my student's healthcare professional has prescribed adrenal insufficiency medication for him/her.
☐ Yes ☐ No I request that the school identify and train employees who are willing to volunteer to administer medication for adrenal insufficiency.
☐ Yes ☐ No I authorize a trained school employee volunteer to administer medication for adrenal insufficiency.

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: