# *Loudoun County Public Schools*
# *Adrenal Insufficiency Action Plan / Physician's Order*

Place Student's Picture Here

***Student's Information***

Last Name: _____ First Name: _____ DOB: _____

Student ID # _____ School: _____ Grade: _____

Parent/Guardian: _____ Cell: _____ SY: _____

**To be completed by a Licensed Healthcare Provider (Physician, Physician's Assistant, or Nurse Practitioner)**

☐ Daily Maintenance Medication

Name of Medication: _____ Dosage: _____ Route: _____

Time to be administered: _____ Length of Time: ☐ School Year ☐ Other: _____

☐ Oral Stress Dose

Name of Medication: _____ Dosage: _____ Route: _____

**Give oral stress dose immediately AND call parent for one or more of the checked symptoms:**

☐ oral temperature above 101°F ☐ _____ ☐ _____

☐ _____

☐ Emergency Solu-Cortef IM

Name of Medication: _____ Dosage: _____ Location: _____

**Give Solu Cortef IM immediately for one or more of the checked symptoms:**

☐ oral temperature above 101°F AND unable to take oral stress dose ☐ vomiting >1 time

☐ severe injury- broken bone/deep cut/concussion

☐ sudden confusion/loss of consciousness

☐ _____ ☐ _____

**CALL 911- State that the student is in adrenal crisis and has received Solu-Cortef.**

☐ **Healthcare Provider's note should accompany student to the Emergency Department.**

☐ **Student may carry and consume water, Gatorade, and snacks as needed.**

☐ **Other:** _____

**Healthcare Provider's Name (Print/stamp):** _____

**Healthcare Provider's Signature:** _____ **Date:** _____

**National Provider Identifier (NPI):** _____ **Phone:** _____

Parent/Guardian Name: _____ Phone: _____

I give my permission for the school nurse and/or designated trained school professional, to administer prescribed medication including Solu-Cortef, or it's generic, to my child, as prescribed by his/her physician. I understand that 911 will be called anytime Solu-Cortef is administered to my child. I understand that the school nurse may contact the prescribing provider with clarifying questions regarding the medication and order. My signature releases the school district, and its employees from any and all claims, liabilities, actions, and judgements related to providing emergency care to my child in accordance to Virginia Code §8.01-225. I understand that if I do not pick up medication at the end of the school year it will be discarded.

Parent/Guardian Signature: _____ Date: _____

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*Page 2 for LCPS Health Office Use*

| To Be Completed with Health Office Staff |
| --- |
| Oral Medication received:_____ Expiration Date: _____<br><br>Injectable Medication received:_____ Expiration Date: _____<br><br>Medication received by:_____/ _____<br>Health Office Staff Signature/ Date Parent Signature/ Date |