LOS ANGELES UNIFIED SCHOOL DISTRICT
District Nursing Services

DAILY ADRENAL INSUFFICIENCY MEDICATION CHECKLIST

_____
Student Name Date of Birth

Inspect applicable equipment/supplies below daily. Check off each appropriate item as inspected. Enter any applicable remarks and initial. If student is absent, write "A" for the designated day. The person administering care is responsible for care of equipment and shall inspect equipment as noted above.

LICENSED NURSE PROVIDER SIGNATURE

DATE	SIGNATURE	INITIAL

SCHOOL NURSE WEEKLY CHECKLIST REVIEW

DATE	SIGNATURE

Month/Year (mm/yy):	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F	M	T	W	T	F
Date (dd):																				
Emergency Solu-Cortef Injection Kit labeled with student's name																				
Hydrocortisone oral medication labeled with student's name																				
Initials																				

Comments: