LOS ANGELES UNIFIED SCHOOL DISTRICT
District Nursing Services

AUTHORIZATION FOR EMERGENCY MEDICATION FOR ADRENAL INSUFFICIENCY
and
STUDENT EMERGENCY CARE PLAN

Student Name	***Date of Birth (DOB)***	***Gender***
Student Diagnosis	***School***	***School Phone***

Dear Parent/Legal Guardian:

If your child has been diagnosed with Adrenal Insufficiency, please have the student's primary healthcare provider fill out this form and attach any additional orders/instructions, if necessary.

STRESS DOSING (ADMINISTERED AT SCHOOL) **TO BE FILLED OUT BY THE PRIMARY HEALTHCARE PROVIDER ONLY**	
SEVERITY	**ACTION**
Mild to Moderate Stress Dosing For illness such as poor appetite, headache, flu-like symptoms, COVID, weakness, mild-moderate head or body trauma, temp = 100.5F - 102F.	1. Administer hydrocortisone 2. School personnel must call parent/guardian or alternate emergency contact if any stress dose is given. ✓ _____ *Total mg per tablet(s)or capsule(s)* ✓ _____ *Dose: # tablet(s)or capsules to be given* ✓ _____ *Route* ✓ _____ *Frequency* If, after receiving oral hydrocortisone, the student begins to display one or more of the severe signs and symptoms below, follow the steps below. ⬇

NAME: _____ DOB:_____GENDER:_____

Moderate to Severe Stress Dosing For illness such as vomiting, diarrhea, moderate-severe head or body trauma, temp > 102F.	1. Administer hydrocortisone 2. School personnel must call parent/guardian or alternate emergency contact if any stress dose is given. ✓ $\frac{}{Total\ mg\ per\ tablet(s) or\ capsule(s)}$ ✓ $\frac{}{Dose: \#\ tablet(s) or\ capsules\ to\ be\ given}$ ✓ $\frac{}{Route}$ ✓ $\frac{}{Frequency}$ If, after receiving oral hydrocortisone, the student begins to display one or more of the severe signs and symptoms below, follow the steps below. ⬇
<u>Emergency Stress Dosing</u> For illness such as vomiting or diarrhea more than once within 20 minutes of taking oral dose, severe head and/or body trauma, profuse bleeding, altered mental status, lethargy, loss of consciousness/fainting, seizure activity, or cannot take oral stress dose. ***See LAUSD Nursing Services Solu-Cortef Injection Administration Guidelines. ACTIVATE EMS/CALL 911**	1. Administer **<u>EMERGENCY</u>** Injectable dose (Act-o-vial) Solu-Cortef ★ If licensed personnel are not on campus and parent is unable to come to school immediately, school staff to call paramedics (911) to transport student to Emergency facility as soon as possible. Give copy of this form and the Solu-Cortef (Act-o-vial) to paramedics. ✓ $\frac{}{Total\ mg/ml}$ ✓ $\frac{}{Dose: ml\ to\ be\ given}$ ✓ $\frac{}{Route}$ ✓ $\frac{}{Frequency}$ 2. Activate EMS/Call 911 3. Contact parent/guardian immediately. If parent/guardian cannot be reached, contact emergency contact(s)

NAME: _____ DOB:_____GENDER:_____

DAILY MEDICATION DOSES FOR DISASTER PREPAREDNESS ONLY

TO BE FILLED OUT BY THE PRIMARY HEALTHCARE PROVIDER ONLY

NAME	DOSAGE
☐ Hydrocortisone/Cortef _____ $mg\ per\ Tablet(s)\ or\ Capsule(s)$	_____ $Total\ mg$ _____ $\#\ Tablet(s) or\ Capsule(s) to\ be\ given$
☐ Fludrocortisone acetate _____ $mg\ per\ Tablet(s)\ or\ Capsule(s)$	_____ $Total\ mg$ _____ $\#\ Tablet(s) or\ Capsule(s) to\ be\ given$
☐ Sodium chloride/NaCL _____ $mEq/ml\ or\ mg\ per\ Tablet(s) or Capsule(s)$	_____ $Total\ mEq/ml\ or\ mg$ _____ $\#\ Tablet(s) or\ Capsule(s) to\ be\ given$

NOTE: STANDARD EMERGENCY CARE PROCEDURE FOR SOLU-CORTEF INJECTION ADMINISTRATION IS ATTACHED. PLEASE REVIEW AND CHECK APPROPRIATE BOX TO INDICATE AUTHORIZATION.

✓ Check one:

☐ I have reviewed and approved the attached standardized procedures as written.

☐ I have reviewed and approved the attached standardized procedures as written with the attached modifications.

☐ I **DO NOT APPROVE** of LAUSD's standardized procedures and have attached an alternative procedure.

Authorized Healthcare Provider Authorization for SOLU-CORTEF INJECTION ADMINISTRATION: School Setting

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that initial emergency management services may be performed by a licensed nursing provider (School Nurse or LVN) or by a school physician. This authorization is for a maximum of one year. If changes are indicated, I will provide the written authorization. Authorizations may be faxed or e-mailed.

_____ _____ _____

Authorized Healthcare Provider Name *Signature* *Date*

Nurse Practitioner, Nurse Midwife, Physician Assistant | Furnishing #_____

Print the Name of the Supervising Physician _____

_____ _____

Address *City* *Zip* *Phone*

NAME: _____ DOB:_____GENDER:_____

Parent Consent for Authorization and Management of SOLU-CORTEF INJECTION ADMINISTRATION: School Setting

I (we) the undersigned, the parent/legal guardian(s) of the above-named student, request that the above standardized procedure be administered to my (our) child in accordance with state laws and regulations. I (we) will:

1. Provide the necessary supplies and equipment.
2. Notify the school nurse if there is a change in child's health status or attending healthcare provider.
3. Notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization.
4. Provide new written consent/authorization yearly.

I (we) give consent for the school nurse to communicate with the authorized healthcare provider when necessary.

Parent(s) or Guardian(s) Name	*Signature*	*Date*

Home phone #	*Workphone #*	*Cellular phone #*

Emergency Contact

Parent/Legal Guardian	*Work #*	*Home #*	*Cellular #*
Parent/Legal Guardian	*Work #*	*Home #*	*Cellular #*
Healthcare Provider	*Work #*		*Alt. Phone #*
Alt. Emergency Contact	*Work #*	*Home #*	*Cellular #*

Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines

Printed Name of Nurse	*Signature*	*Title (LVN, RN)*	*Date*

Instructions for Using Emergency Solu-Cortef Injection

Your Emergency Solu-Cortef™ (hydrocortisone) Injection Kit

Your Emergency Injection Kit needs to contain:

- 1 x 2mL Solu-Cortef™ ACT-O-VIAL®
- 2 x Alcohol Swabs
- 1 x 3mL Single Use Syringe
- 1 x Vial Access Cannula or Drawing Up Needle
- 1 x Injection Needle
- 1 x Cotton Swab

STEP 1

Preparation:

- Wash your hands thoroughly before preparing the injection.
- Check the label to ensure you have Solu-Cortef™.
- Check the expiry date on the ACT-O-VIAL®.

STEP 2

- Tap to ensure that powder is at base of vial and away from the central stopper.
- Put the ACT-O-VIAL® on a hard surface.
- Place the palm of your hand on the lid of the ACT-O-VIAL®.
- Press down firmly on the lid to force the liquid into the bottom chamber.

STEP 3

- Gently mix the solution without shaking it.
- Rotate the ACT-O-VIAL® turning it upside down a number of times.
- **DO NOT SHAKE**
- The solution is initially cloudy but will become clear.

STEP 4

- Remove the plastic tab that covers the rubber stopper with your thumbnail.

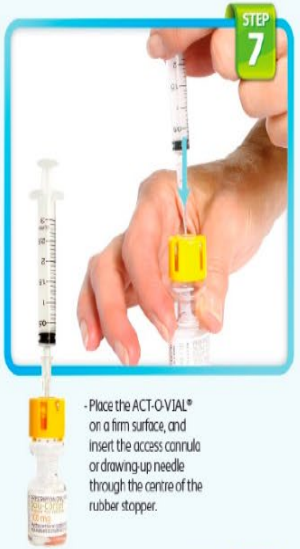
STEP 5

- Wipe the top of the ACT-O-VIAL® with an alcohol swab.

STEP 6

- Connect the 3 mL syringe and the vial access cannula or drawing-up needle firmly together.

STEP 7



- Place the ACT-O-VIAL® on a firm surface, and insert the access cannula or drawing-up needle through the centre of the rubber stopper.

STEP 8

- With the access cannula or drawing up needle in the ACT-O-VIAL®, invert the bottle and withdraw the correct dose ordered by your doctor.

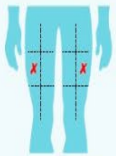
NOTE: If using a drawing up needle, keep the needle tip below the fluid level.

STEP 9

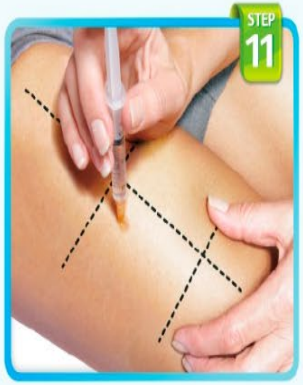
- Withdraw the syringe from the ACT-O-VIAL®.
- Remove the access cannula or drawing up needle and replace it with the injection needle. Use the needle size recommended by your clinic nurse.
- Flick the syringe to remove any bubbles.
- Expel any excess air.

STEP 10

- Divide the thigh into 3 sections.
- Clean the leg area with an alcohol swab **BEFORE** injection.
- Give the injection in the outer middle third of the thigh.



STEP 11



- Holding the syringe firmly, give the injection by quickly inserting the needle fully through the skin surface into the muscle layer.
- Push the plunger until the dose is fully injected. This will only take around 10 seconds.

STEP 12

- Remove the needle, do not recap.
- Dispose of the needle in a **SHARPS CONTAINER**
- Press the cotton swab firmly over the site for a few seconds.
- The injection will work quite quickly, but supervision is still required.
- Reassure and take the patient to hospital for review as soon as possible.