




NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ GENDER: \_\_\_\_\_

<p style="text-align: center;"><b>Moderate to Severe Stress Dosing</b></p> <p>For illness such as vomiting, diarrhea, moderate-severe head or body trauma, temp &gt; 102F.</p>	<ol style="list-style-type: none"> <li>1. Administer hydrocortisone</li> <li>2. School personnel must call parent/guardian or alternate emergency contact if any stress dose is given.</li> </ol> <p>✓ _____ <i>Total mg per tablet(s) or capsule(s)</i></p> <p>✓ _____ <i>Dose: # tablet(s) or capsules to be given</i></p> <p>✓ _____ <i>Route</i></p> <p>✓ _____ <i>Frequency</i></p> <p>If, after receiving oral hydrocortisone, the student begins to display one or more of the severe signs and symptoms below, follow the steps below. </p>
<p style="text-align: center;"><b>Emergency Stress Dosing</b></p> <p>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.</p> <p><b>*See LAUSD Nursing Services Solu-Cortef Injection Administration Guidelines. ACTIVATE EMS/CALL 911</b></p>	<ol style="list-style-type: none"> <li>1. Administer <b>EMERGENCY</b> Injectable dose (Act-o-vial) Solu-Cortef             <ul style="list-style-type: none"> <li>★ 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.</li> </ul> </li> </ol> <p>✓ _____ <i>Total mg/ml</i></p> <p>✓ _____ <i>Dose: ml to be given</i></p> <p>✓ _____ <i>Route</i></p> <p>✓ _____ <i>Frequency</i></p> <ol style="list-style-type: none"> <li>2. Activate EMS/Call 911</li> <li>3. Contact parent/guardian immediately. If parent/guardian cannot be reached, contact emergency contact(s)</li> </ol>

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**DAILY MEDICATION DOSES FOR DISASTER PREPAREDNESS ONLY**  
**TO BE FILLED OUT BY THE PRIMARY HEALTHCARE PROVIDER ONLY**

NAME	DOSAGE
<input type="checkbox"/> Hydrocortisone/Cortef  <hr style="width: 80%; margin: 0 auto;"/> <p style="text-align: center;"><i>mg per Tablet(s) or Capsule(s)</i></p>	<hr style="width: 80%; margin: 0 auto;"/> <p style="text-align: center;"><i>Total mg</i></p> <hr style="width: 80%; margin: 0 auto;"/> <p style="text-align: center;"><i># Tablet(s) or Capsule(s) to be given</i></p>
<input type="checkbox"/> Fludrocortisone acetate  <hr style="width: 80%; margin: 0 auto;"/> <p style="text-align: center;"><i>mg per Tablet(s) or Capsule(s)</i></p>	<hr style="width: 80%; margin: 0 auto;"/> <p style="text-align: center;"><i>Total mg</i></p> <hr style="width: 80%; margin: 0 auto;"/> <p style="text-align: center;"><i># Tablet(s) or Capsule(s) to be given</i></p>
<input type="checkbox"/> Sodium chloride/NaCL  <hr style="width: 80%; margin: 0 auto;"/> <p style="text-align: center;"><i>mEq/ml or mg per Tablet(s) or Capsule(s)</i></p>	<hr style="width: 80%; margin: 0 auto;"/> <p style="text-align: center;"><i>Total mEq/ml or mg</i></p> <hr style="width: 80%; margin: 0 auto;"/> <p style="text-align: center;"><i># Tablet(s) or Capsule(s) to be given</i></p>

**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: \_\_\_\_\_

**Consentimiento del Padre o Madre para Autorizar y Controlar la ADMINISTRACIÓN DE LA INYECCIÓN SOLU-CORTEF: En la Escuela**

Yo (nosotros) el/la/los abajo firmante (s), padre, madre, padres o tutor (es) del estudiante cuyo nombre aparece anteriormente, solicitamos que el procedimiento estandarizado que se menciona anteriormente sea administrado a mi (nuestro) hijo (a) de conformidad con las leyes y reglamentos estatales. Yo (nosotros):

1. Proveeremos los materiales y equipo necesarios.
2. Notificaremos a la enfermera escolar si se presenta algún cambio en el estado de salud del niño (a) o en el proveedor de atención médica.
3. De inmediato, notificaremos a la enfermera escolar y proveeremos un nuevo consentimiento o autorización por escrito para todo cambio relacionado con la autorización anterior.
4. Y anualmente, proveeremos un consentimiento o autorización escrito nuevo.

Yo (nosotros) otorgamos consentimiento a la enferma escolar para que se comuniqué con el proveedor de atención médica autorizado cuando sea necesario.

_____	_____	_____
<i>Nombre del padre o tutor</i>	<i>Firma</i>	<i>Fecha</i>
_____	_____	_____
<i>Teléfono de Casa #</i>	<i>Teléfono de Trabajo #</i>	<i>Teléfono Celular #</i>

**Emergency Contact**

_____	_____	_____	_____
<i>Madre o Tutor</i>	<i>Teléfono de Trabajo #</i>	<i>Teléfono de Casa#</i>	<i>Teléfono Celular #</i>
_____	_____	_____	_____
<i>Padre o Tutor</i>	<i>Teléfono de Trabajo #</i>	<i>Teléfono de Casa#</i>	<i>Teléfono Celular #</i>
_____	_____	_____	_____
<i>Proveedor de atención médica</i>	<i>Teléfono de Trabajo #</i>	<i>Teléfono alternativo #</i>	
_____	_____	_____	_____
<i>Contacto de emergencia alternativo</i>	<i>Teléfono de Trabajo #</i>	<i>Teléfono de Casa #</i>	<i>Teléfono Celular #</i>

**Licensed Nurse Acknowledgement of Completeness and Meets District Guidelines**

_____	_____	_____	_____
<i>Printed Name of Nurse</i>	<i>Signature</i>	<i>Title (LVN, RN)</i>	<i>Date</i>



## 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<sup>®</sup> ACT-O-VIAL<sup>®</sup>
  - 2 Alcohol Swabs
  - 1 x 3mL Single Use Syringe
  - 1 x Vial Access Camula or Drowning Up Needle
  - 1 x Injection Needle
  - 1 x Cotton Swab

**STEP 1**

**Preparation:**

- Wash your hands thoroughly before preparing the injection.
- Check the blue to assure you have Solu-Cortef<sup>®</sup>.
- Check the expiry date on the ACT-O-VIAL<sup>®</sup>.

**STEP 2**

- Tip to ensure that powder is at base of vial and away from the central stopper.
- Put the ACT-O-VIAL<sup>®</sup> on a hard surface.
- Place the palm of your hand on the lid of the ACT-O-VIAL<sup>®</sup>.
- 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<sup>®</sup> turning it topside down a number of times.
- **DO NOT SHAKE**
- The solution is initially cloudy but will become clear.

**STEP 4**

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

**STEP 5**

- Wipe the top of the ACT-O-VIAL<sup>®</sup> with an alcohol swab.

**STEP 6**

- Connect the 3mL syringe and the vial access camula or drowning up needle firmly together.

**STEP 7**

- Place the ACT-O-VIAL<sup>®</sup> or a firm surface, and insert the access camula or drowning up needle through the centre of the rubber stopper.

**STEP 9**

- Withdraw the syringe from the ACT-O-VIAL<sup>®</sup>.
- Remove the access camula or drowning 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 8**

- With the access camula or drowning up needle in the ACT-O-VIAL<sup>®</sup>, insert the needle and withdraw the correct dose ordered by your doctor.
- NOTE:** If using a drowning up needle, keep the needle tip below the fluid level.

**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 suspension is still required.
- Reassure and take the patient to hospital for review as soon as possible.