Galloway Township Public Schools
101 South Reeds Road
Galloway, NJ 08205
(609) 748-1250
http://www.gtps.k12.nj.us

HYDROCORTISONE SODIUM SUCCINATE – ACTION Plan
Parent Permission/Physician's Order

Dear Parent/Guardian:

You have informed the school nurse that your child experiences adrenal insufficiency. In cooperation with your child's physician, please complete all information below and return it to the school nurse with your child's medication. **This form is only valid for the current school year.**

Student's Name: _____ Grade: _____ Date of Birth: _____

1. **EMERGENCY PHONE NUMBERS** (*PARENT COMPLETE*)

Parent/Guardian: Home/Cell_____ Work_____
Parent/Guardian: Home/Cell_____ Work_____
Other: Name_____ Relationship _____
Home/Cell_____ Work _____
Preferred hospital_____

I understand this information may be shared with appropriate staff members having contact with my child. I understand that in the event of a school function where my child is not able to self-administer, I will contact the school nurse in advance to discuss a suitable accommodation.

_____ _____
Parent's/Guardian's Signature Date

2. TO BE COMPLETED BY PHYSICIAN

MEDICATION ORDER:
Name of medication_____ Diagnosis _____
Dosage _____ Route _____Time _____
Frequency/Duration _____Purpose of medication_____
List Indications for use _____
Possible Side effects _____
Duration of order _____
List other medications child is on which may enhance, alter or impact this medication _____
_____
Is child capable of and may self-administer this medication? _____ YES _____NO

This medication must be administered during the school day or during school activity or function in order for student to be able to attend or benefit from the instruction or services being provided by the school district.

Physician/Health Care Provider's Signature/Stamp Date
_____

Please Print Physician/Health Care Provider's Name, Address, and Phone Number

3. PARENT PERMISSION TO ADMINISTER MEDICATION

I request and grant permission for the school nurse to administer medication to my child, _____ as prescribed by his/her physician as indicated on the reverse side this form and as per the policy of the Galloway Township Board of Education and State law.

_____ _____ _____

Parent's/Guardian's Signature Date Phone Number

4. PUPIL SELF-ADMINISTRATION OF HYDROCORTISONE SODIUM SUCCINATE

The Board of Education shall permit self administration of medication for **asthma, diabetes, hydrocortisone sodium succinate, or other potentially life-threatening illnesses** by pupils in grades 1 through 8 who have the capability for self-administration of medication, both on school premises during regular school hours and off site or after regular school hours when a pupil is participating in field trips or extracurricular activities and the school nurse and his/her designee is not present.

I, _____ give permission for my child, _____to self-medicate with _____(medication) as prescribed by _____(doctor) for **adrenal insufficiency** both on school premises during regular school hours and off-site or after regular school hours when they are participating in field trips or extracurricular activities and the school nurse and his/her designee is not present. My child is capable of self-medication and has been instructed on the proper administration of his/her medication.

I acknowledge that the Galloway Township Public Schools shall incur no liability as a result of any injury arising from the self-administration of medication by my child and that I indemnify and hold harmless the District and its employees or agents against any claims arising out of self-administration of medication by my child. I acknowledge that my child's right to self-administer may be revoked provided they are not a danger to themselves or other persons through misuse.

_____ _____

Parent's/Guardian's Signature Date

5. PARENT PERMISSION FOR DESIGNEE TO ADMINISTER

In the absence of the school nurse, I **GRANT** permission for a trained delegate to administer my child's hydrocortisone sodium succinate as medically ordered. I acknowledge that the district and its employees or agents shall have no liability as a result of any injury arising from the administration of hydrocortisone sodium to my child.

*If you do NOT GRANT permission for a delegate to administer this medication, please do NOT sign below.

_____ _____

Parent's/Guardian's Signature Date

_____ _____

School Nurse Signature Date

_____ _____

Principal Signature Date