MOLALLA RIVER SCHOOL DISTRICT

AUTHORIZATION FOR EMERGENCY SOLU-CORTEF/SOLU-MEDROL

Student: DOB:

School:

As the parent or guardian of the above referenced student, I request that my child receive the following specialized health services: *Response to Adrenal Crisis including administration of emergency injection as per physician's orders and nursing protocol.*

Medication: ☐ Solu-Cortef ☐ Solu-Medrol
☐ Act-o-vial
☐ Reconstitution

Route: Subcutaneous Injection
For: Adrenal Crisis: Lethargy, abdominal pain, vomiting, lower back pain, confusion, extreme weakness, hypotension, tachycardia, fever, dizziness or loss of consciousness.

I understand that:

- This authorization is valid for one year from the date of my signature below.
- Qualified, designated persons will be performing the above-mentioned health care service(s) and the designated persons will receive mandated adrenal insufficiency/ adrenal crisis training (ORS 4330800-830; OAR 333-055-0000-0035) and supervised by a registered nurse as authorized by OAR 851-047-0000.
- I will notify the school immediately if the health status changes, if there is a change of physicians, changes to physician's orders, and/or change or cancellation of health care.
- I am responsible for bringing to school all necessary supplies and medications to school and am required to bring current medical orders to school that include medication administration.

Parents Signature Date