Children's Hospital LOS ANGELES
CENTER FOR ENDOCRINOLOGY, DIABETES AND METABOLISM

MEDICATION ADMINISTRATION SCHOOL FORM

Student name _____ _____ _____
Last First Gender DOB

Name of Medication: _**Solucortef (100/ 2 mL)**____ Date of prescription:_____

Dose prescribed: _____ Dose form __**Injection**_____
(Tablet, liquid, injection, etc.)

Route: __**IM Injection**____ Time scheduled: __**PRN Emergency Stress Illness**____

Diagnosis or purpose of medication:___**Adrenal Insufficiency**_____

___ Needs total/ partial assistance with medication ____ Self- sufficient with medication

Special Instructions and/ or comments: **__administer injection prn emergency stress illness within 10- 15 minutes such as vomiting or diarrhea x 2 or more within 30 minutes, severe head trauma, profuse bleeding, seizure activity, lethargy or loss of consciousness. Contact mom and Endocrine doctor immediately**.

The student for whom this medication is prescribed is under my care.

_____
Print name/ Title Signature Date

4650 Sunset Blvd. Los Angeles, CA 90027 (323) 361- 2129

_____ _____
Address City State Zip Code Telephone

I authorize Children's Hospital of Los Angeles Center for Endocrinology, Diabetes & Metabolism to release my child,

_____'s medical information which includes Diagnosis and Treatment to

_____ School.

_____ _____ _____
Date Signature of Parent/ Guardian Print Name

(___)_____ (___)_____ (___)_____
Home telephone Cell telephone Work telephone