



# Student Health Services

## Sickle Cell Health Care Plan

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Teacher:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **School:** \_\_\_\_\_

**Parent/Guardian Information:**

Mother's Name: _____	Father's Name: _____
Home #: _____	Home#: _____
Work #: _____	Work #: _____
Mobile/Other: _____	Mobile/Other: _____
Address: _____	Address: _____
Email: _____	Email: _____

**Note: This student has a health condition of which the school system staff needs to be aware. Care during school hours, emergency care, and individual considerations are stated below:**

**Goals and School Tips to Prevent/Decrease Sickle Cell Events**

1. Maintain adequate hydration, water bottle kept with student and available to drink at all times. Unlimited bathroom privileges
2. Exercise based on tolerance
3. Avoid extremes in hot/cold temperatures, dress appropriate for weather
4. Staff awareness of signs/symptoms and treatments of sickle cell events

**\*CIRCLE SYMPTOMS THAT YOUR CHILD MAY PRESENT WITH DURING A SICKLE CELL CRISIS**

Pain: List Locations: \_\_\_\_\_  
 Fever/temperature \_\_\_\_\_  
 Fatigue/Weakness \_\_\_\_\_  
 Pale or Jaundice colored skin \_\_\_\_\_  
 Cough / Shortness of Breath / Increased heart rate \_\_\_\_\_  
 Vomiting/Diarrhea \_\_\_\_\_  
 Unusual behavior/ Refusal to eat/drink \_\_\_\_\_

**\*Staff to note time, duration and intensity of symptoms that occur.**

**Possible Symptoms**

**Action**

- |   |  |
|---|--|
| <ol style="list-style-type: none"> <li>1. Fatigue</li> <br/> <li>2. Pain: mild to moderate<br/>Arms/legs/chest/abdomen</li> </ol> | <ol style="list-style-type: none"> <li>A. Exercise based on tolerance</li> <li>B. Rest as needed</li> <br/> <li>A. Stop activity and rest</li> <li>B. Give fluids/ carry water bottle</li> <li>C. Warm compresses to site if helpful</li> <li>D. Medication per Authorization Form:<br/>Medication _____</li> <li>E. Call parents to notify</li> <li>F. Use coping strategies, divert attention, calm/reassure</li> <li>G. Loosen tight or restrictive clothes</li> <li>H. Reevaluate pain after comfort measures in place.</li> </ol> |
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- 3. Severe Pain, swollen and painful abdomen, pallor, lethargy, possible shock
  - A. Seek immediate medical attention-Call 911. Notify parent.
  
- 4. Fever
  - A. Call parent for any temp greater than \_\_\_\_\_
  - B. Over 100.4 degrees, go home
  - C. Give fluids
  - D. Keep in clinic until parent/guardian arrives
  
- 5. Signs of stroke: signs may include: severe headache, weakness on one side, facial asymmetry, difficulty swallowing, slurred speech, seizure
  - A. Contact parent immediately
  - B. If parent not available, or if student has a change in mental status and or/ has an extended seizure call 911

**Additional Actions/Considerations for School:**

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**I am the parent/guardian of \_\_\_\_\_ and request that the Sickle Cell Health Care Plan be utilized during school hours.**

**School employees will not assume any liability for supervising or assisting in the utilization of this health care plan. Completion of this Sickle Cell Health Care Plan authorizes Student Health Services to discuss the health care plan with the appropriate school staff and prescribing health care provider via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child.**

**Physician/Health Care Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**Physician name (print)/phone number: \_\_\_\_\_**

**Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_**