Student Health Services

Sickle Cell Health Care Plan

Student Name: _____ Date of Birth: _____

Teacher: _____ Grade: _____ School: _____

Parent/Guardian Information:

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

Father's Name: _____
Home#: _____
Work #: _____
Mobile/Other: _____
Address: _____
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, carry water bottle
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
***Please note time, duration and intensity of symptoms that occur.**

Possible Symptoms	***Action***
1. Fatigue	A. Exercise based on tolerance B. Rest as needed
2. Pain: mild to moderate Arms/legs/chest/abdomen	A. Stop activity and rest B. Give fluids/ carry water bottle C. Warm compresses to site if helpful D. Medication per Authorization Form: Medication_____ E. Call parents to notify F. Use coping strategies, divert attention, calm/reassure G. Loosen tight or restrictive clothes H. Reevaluate pain after comfort measures in place.

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3. Severe Pain, swollen and painful abdomen, pallor, lethargy, possible shock, vomiting, diarrhea.	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

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: _____