# 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, 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**
**Clinic will notify parent of any symptoms below that occur**

Pain: List Locations: _____
Fever/temperature
Fatigue/Weakness
Pale or Jaundiced skin
Wheezing/Difficulty Breathing/Persistent cough/Shortness of Breath/Increased heart rate
Vomiting/Diarrhea
Unusual behavior/ Refusal to eat/drink
Other/Comments: _____
_____

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

Fulton County Schools
Where Students Come First

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| | |
|---|---|
| 3. Severe Pain, swollen and painful abdomen, pallor, lethargy, possible shock | A. Seek immediate medical attention-Call 911.<br>B. Notify parent |
| 4. Fever | A. Call parent for any temp greater than _____<br>B. Over 100.4 degrees, go home<br>C. Give fluids<br>D. Keep in clinic until parent/guardian arrives<br>E. Student must be seen in Sickle Cell Clinic or in the ER if temp >101 degrees |
| 5. Signs of stroke: signs may include: severe headache, weakness on one side, facial asymmetry, difficulty swallowing, slurred speech, seizure) | A. If student has signs of stroke, change in mental status, and or/ has an extended seizure call 911<br>B. Notify Parent immediately |

**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: _____**