



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
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

- | | |
|---|---|
| <ol style="list-style-type: none"> 1. Fatigue
 2. Pain: mild to moderate
Arms/legs/chest/abdomen | <ol style="list-style-type: none"> A. Exercise based on tolerance B. Rest as needed
 A. Stop activity and rest B. Give fluids/ carry water bottle C. Warm compresses to site if helpful D. Pain 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
 - A. Seek immediate medical attention-Call 911.
 - B. 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
 - 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
 - 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: _____