School Health Services

Sickle Cell Health Care Plan

Student Name: _____ **Date of Birth:** _____

Teacher:_____ **Grade:** _____ **School:** _____

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 should always be kept with student and available to drink.
2. Unlimited bathroom privileges
3. Exercise based on tolerance
4. Avoid extremes in hot/cold temperatures, dress appropriate for weather
5. Staff awareness of signs/symptoms and treatments of sickle cell events

CHECK 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 Jaundice colored skin
☐ 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 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. 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
3. Severe Pain, swollen and painful abdomen, pallor, lethargy, possible shock	A. Seek immediate medical attention-Call 911. B. Notify parent

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4. Fever	A. Call parent for any temp greater than over 100.4 degrees B. Give fluids C. Keep in clinic until parent/guardian arrives D. 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 District 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 # _____

Parent Signature _____ Date: _____

Parent Name (Print) _____Phone # _____

Received by _____Date:_____

Date Reviewed by Cluster Nurse/Special Education Nurse: _____

Cluster Nurse/Special Education Nurse Signature: _____