



Carroll County Public Schools
Parent Health Questionnaire – Sickle Cell Disease
School Year: _____

Student Name: _____
Date of Birth: _____ Grade: _____

You have indicated on the Emergency Procedure Card and/or health forms that your child has a history of sickle cell disease/trait. Please complete the following questionnaire and return to your school nurse as soon as possible.

Hospitalization has been required for Sickle Cell Disease? Yes ☐ No ☐

Date of last admission _____

Current Medications/dosage: _____

Treatment regimen:

Please check the symptoms/triggers that your child has experienced that may indicate a sickle cell crisis:

Stress ☐	Dehydration ☐	Lack of Sleep ☐	Extreme Physical Activity ☐
Caffeine ☐	Heat above ____F ☐	Heat below ____F ☐	Pain ☐ Normal pain level _____
(0-no pain to 10-extreme pain)			

Description of student specific symptoms when a Vasco-occlusive/pain crisis occurs:

How many episodes of crisis does student have per year? _____

Student is able to recognize signs and symptoms of Sickle Cell Disease crisis: Yes ☐ No ☐

- Student is encouraged to wear a medical ID bracelet identifying the medical condition.

Health Care Provider Name: _____ Phone Number: _____

Parent/Guardian Name (Print): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Received by School Nurse

Nurse Signature: _____ Review Date: _____

Revised 12/2020