

## Student 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 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

#### 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<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 |
| 3. Severe Pain, swollen and painful<br>abdomen, pallor, lethargy, possible<br>shock | A. Seek immediate medical attention-Call 911.<br>B. Notify parent   |

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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 # \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date: \_\_\_\_\_

Parent Name (Print) \_\_\_\_\_ Phone # \_\_\_\_\_

Received by \_\_\_\_\_ Date: \_\_\_\_\_

Date Reviewed by Cluster Nurse/Special Education Nurse: \_\_\_\_\_

Cluster Nurse/Special Education Nurse Signature: \_\_\_\_\_