

Bibb County School District

SICKLE CELL PLAN

STUDENT NAME _____ DOB ____/____/____ HR _____

PARENT/GUARDIAN _____ PHONE 1- _____ 2- _____

OTHER CONTACT _____ PHONE 1- _____ 2- _____

MEDICAL CONDITION MAY ADVERSELY AFFECT THE STUDENT IN THE FOLLOWING AREAS:

ATTENDANCE : ____ extended absences ____ intermittent absences ____ inability to attend a full academic schedule
 ____ other comments regarding attendance _____

ALERTNESS : ____ normal ____ heightened alertness to environmental stimuli ____ decreased alertness
 ____ other _____

ATTENTION: ____ normal ____ decreased ability to attend task ____ other _____

OTHER AREAS AFFECTED BY SICKLE CELL CONDITION (please explain):

PHYSICAL FUNCTION: ____ normal ____ limited (explain) _____

PHYSICAL EDUCATION: ____ the following modifications are required for P.E.: may participate in activities as tolerated: provide free access to water and bathroom: allow for rest breaks: avoid physical exhaustion: avoid temperature extremes.

CHECK ONE: ____ may participate in P.E. with above modifications ____ may not participate in P.E. until ____/____/____

MEDICAL NEEDS DURING THE SCHOOL DAY:

____ May need the following medication at school for pain : _____
 ____ Water bottle at desk ____ additional restroom breaks ____ avoid temperature extremes ____ avoid physical exhaustion
 ____ allow student to use a rolling backpack ____ when absent, provide makeup work and allow additional time to complete work and test. ____ other _____

SYMPTOMS THAT MAY INDICATE POTENTIAL MEDICAL PROBLEMS & ACTION REQUIRED:

	REQUIRED ACTION
Fever 101 degrees or over	Contact parent immediately. Parent to contact doctor or EC
Pain	Administer pain medication as directed by doctor.
Wheezing, difficulty breathing, persistent cough	Administer inhaler if prescribed. Call parent. If emergency call 911
Signs of stroke: very severe headache, weakness on one side, facial asymmetry, difficulty swallowing, slurred speech, seizure	Call 911 . Contact parent. Administer first aid until help arrives.

Medical Provider Signature _____ Phone _____ Date ____/____/____
 Address _____

Parent/Guardian _____ Date ____/____/____

School Nurse _____ Date ____/____/____

Counselor _____ Date ____/____/____

Signatures confirm an agreement to this plan