

Sickle Cell Disease Plan

Grade _____ School Year _____

Student Name: _____ Date of Birth: _____

School: _____ School Clinic #: _____ School Fax #: _____

Primary Physician: _____ Phone: _____ Fax: _____

Emergency Contact Name	Relationship	Home	Work	Cellular
1.				
2.				
3.				

Sickle cell type: ☐Sickle cell trait ☐HbSS ☐HbSC ☐HbS beta thalassemia a ☐HbSD ☐HbSE ☐HbSO ☐Other **Significant Medical History and/or Allergies:** _____

Wears Medical Alert Bracelet ☐YES ☐NO **Hospitalization for SCD** ☐YES ☐NO **Last Date of Admission:** _____

Student can recognize & get help for early signs of crisis ☐YES ☐NO **Physical Education Restrictions** ☐No ☐Yes, Describe Below: _____

PHYSICIAN COMPLETES FORM FROM THIS POINT FORWARD.

Triggers: ☐Stress ☐Dehydration ☐Temps above ____°F below ____°F ☐Lack of Sleep ☐Strenuous Activity ☐Other _____

Medications prescribed at home only: _____

Specific Individual Considerations:

- ☐ Allow student to self-limit activity, as needed ☐ Allow extra time to and from classes
- ☐ Access to water at all times, allowing for extra hydration during physical activity. This may necessitate having a water bottle. ☐
- Liberal bathroom and/or clinic visits** ☐ May use elevator if applicable

Prevention Measures

- Allow child to stop activity without undue attention
- Allow liberal bathroom/clinic visits
- Do not use ice for injuries
- Administer medication if ordered as needed
- Contact Parents/School Nurse for any questions or concerns
- Allow adequate fluid intake throughout the school day
- Reduce exposure to extreme hot or cold environmental temperatures
- Reduce exposure to communicable disease
- Allow student to rest until medication takes effect

Warning Signs and Symptoms

Fever above ____°F
Joint swelling, pain, heat
Sudden Pallor, blueish lips
Weakness

Fast or difficulty breathing
Headache
Sweating
Pain in hands and feet

1. Notify School Nurse and/or parents for next steps
2. Medication Administration
3. Send Home

CRISIS - EMERGENCY

Sudden and severe Headache
Sudden change in vision
Weakness in limbs
Increasing pain
Extreme Fatigue

Seizure
Slurring Speech
Change in mental status
Abdominal pain/swelling

- ☐Call Parents/Emergency contacts ☐Call 911 for Paramedics
- ☐Notify School Nurse

A "Sickle Cell Crisis Emergency" for this student is additionally defined as:

Treatment and/or Medication Protocol During School Hours

Medication Name	Dosage and Time of Day to be Given	Common Side Effects and Special Instructions

Physician Name/ Signature: _____ **Date:** _____

I give permission for school staff to contact the physician for consultation or exchange of information as needed and for school personnel to follow this plan and provide appropriate medication administration.

Parent/Guardian Signature: _____ **Date:** _____

Health Services Personnel Signature: _____ **Date:** _____

NOTE: This form must be renewed annually or with any change in treatment or medication. The Medication Administration Form must also be completed in addition to the Sickle Cell Disease Plan if medication is required at school or school activities.