HEMOPHILIA (OR OTHER BLEEDING DISORDER) INDIVIDUAL HEALTH PLAN

(Parent/guardian to complete this form)

STUDENT NAME _____ DOB _____ SCHOOL _____

GRADE _____ TEACHER _____ SCHOOL YEAR _____

PARENT/GUARDIAN _____ BEST CONTACT/PHONE NUMBER _____

PHYSICIAN _____ PHONE _____

SPECIALIST _____ PHONE _____

What is the name of your child's condition (hemophilia or other bleeding disorder)?

Please describe what happens with your child during a bleeding episode (symptoms, etc.), including what body parts are usually affected:

How often does your child have bleeding episodes?

What causes your child to have a bleeding episode?

Does your child take a medication at home every day or on a regular basis for this condition? ☐ Yes ☐ No
If yes, what medication?

Does your child have a doctor's order for medication for this condition to be given at school, and is the medication at school? ☐ Yes ☐ No

Has your child needed emergency room treatment for this condition within the past year? ☐ Yes ☐ No
If yes, please describe:

In the event that you cannot be reached, please list the name(s) and phone number(s) of persons who are familiar with your child's hemophilia or other bleeding disorder and have knowledge of how to manage this condition. *Please also add this person(s) to your child's pick-up list in case they may need to pick your child up from school due to their condition.*

Name: _____ Phone Number: _____
Name: _____ Phone Number: _____

Is there anything else you would like school staff to know about your child's hemophilia or other bleeding disorder?

PLEASE NOTE: We recommend talking with your child's doctor to see if they recommend an Emergency Action Plan. Please review the back of this form for steps school staff may take in the event of a medical emergency. These will be followed if your child does not have an Emergency Action Plan at school for this condition.

☐ I give permission for my child, _____, to receive care for the medical condition listed above by designated school staff.
☐ School nurse may share information regarding this condition with my child's doctor.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

SCHOOL NURSE SIGNATURE _____ DATE _____

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STUDENT NAME _____

Note: If student also has an Emergency Action Plan (EAP) for this condition, please refer to the EAP for actions school staff should take instead. Otherwise, follow the steps below.

This student has an EAP: ☐ Yes ☐ No

Symptoms:

- ☐ Pain
- ☐ Swelling
- ☐ Warmth
- ☐ Decreased motion of the joint or muscle

Symptoms that may require medical attention (could indicate a head bleed):

- ☐ Headache
- ☐ Sleepiness
- ☐ Nausea
- ☐ Vomiting
- ☐ Sensitivity to light
- ☐ Loss of consciousness

Symptoms that require immediate medical attention (Call 911):

- ☐ Any uncontrolled bleeding
- ☐ Vomiting of blood

Interventions:

1. Allow student to rest**;** have the student sit or lie quietly until the bleeding episode ends.
2. Apply ice to affected area for 15-20 minutes.
3. Apply pressure to the bleeding site if possible (a bleeding joint can be wrapped with an elastic bandage).
4. Position student so the bleeding area of their body is raised above the level of their heart if possible.
5. Call 911 if indicated as above. Notify front office to direct EMS to student's location.
6. Call or radio for help if needed. Designated first responder school staff should respond to the student's location, and bring any needed emergency equipment.
7. Notify parents/guardians, or designate another staff member to notify:
   Parent/guardian name: _____ Phone number: _____
   Emergency contact name: _____ Phone number: _____
8. Notify school nurse, if in building. If school nurse is not present, notify upon return or via other communication.

Additional information:

_____

_____

Reference: https://www.chop.edu/conditions-diseases/hemophilia Revised 4/2020 ALB