SICKLE CELL ANEMIA 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 are your child's symptoms when a sickle cell crisis is occurring?

Are there any activities or stressors that bring on a pain crisis? ☐ Yes ☐ No If yes, please describe:

Is your child able to recognize and get help for early signs of a crisis? ☐ Yes ☐ No

Does your child take a medication at home every day 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, such as tylenol or ibuprofen, 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 condition and have knowledge of how to manage sickle cell anemia. *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 sickle cell anemia?

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
- ☐ Fatigue
- ☐ Shortness of breath
- ☐ Other: __________________

Symptoms that require immediate medical attention (Call 911):

- ☐ Weakness or numbness of the face, arm or leg, usually on one side of the body
- ☐ Trouble walking due to weakness or trouble moving one side of the body, or due to loss of coordination
- ☐ Problems speaking or understanding language, including slurred speech, trouble trying to speak, inability to speak at all, or difficulty in understanding simple directions
- ☐ Severe headache especially with vomiting and sleepiness
- ☐ Trouble seeing clearly in one or both eyes
- ☐ Severe dizziness or loss of coordination that may lead to losing balance or falling
- ☐ Combination of progressively worsening non-stop headache, drowsiness and repetitive vomiting, lasting
- ☐ days without relief
- ☐ Complaint of sudden onset of the "worst headache of my life"

- ☐ Chest pain and fever (Acute Chest Syndrome)
- ☐ Priapism (erection lasting for more than an hour)

Interventions:

1. Stay with student; student should not leave location or be left alone.
2. Allow student to rest and encourage fluids.
3. Call 911 if indicated as above. Notify front office to direct EMS to student's location.
4. 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.
5. Notify parents/guardians, or designate another staff member to notify:

   Parent/guardian name: ________________ Phone number: ________________

   Emergency contact name: ______________ Phone number: ________________

6. Notify school nurse, if in building. If school nurse is not present, notify upon return or via other communication.

Additional information:

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