SICKLE CELL EMERGENCY ACTION PLAN

NAME: _____Date of Birth: _____
Grade/ Teacher: _____

Contact Information:
Parent/Guardian: _____
Telephone# (w)_____ Telephone # (h) _____
Address: _____
Emergency Contact: _____
Telephone # _____

Physician Treating Student for Sickle Cell: _____Telephone # _____
Other Physician: _____Telephone # _____

EMERGENCY PLAN (Fill in blanks, cross out and initial any steps not needed for this student.)

1. Early warning signs of crisis:
- Joint pain, swelling or warmth in joint
- Fatigue
- Fever (greater than 101°F)
- Headache
- Onset of pale color (pale nailbeds, tissue around eyes)
- Other:_____

2. Steps to take if early warning signs occur:
- Allow to rest
- Encourage fluids
- Contact parent/guardian
- Other: _____

3. Emergency action is necessary when the student has symptoms such as:
- Severe generalized pain
- Severe headache
- One sided weakness, slurred speech
- Abnormal behavior
- Difficulty waking up, listless
- Sudden Significant cough

- Chest pain
- Abdominal swelling, abdominal pain
- Other: _____

4. Steps to take during a Sickle Cell Crisis:

- Contact parent/guardian or doctor's office
- Encourage fluids, if alert
- Call 911 and transport to _____ Hospital
- Other: _____

Sickle Cell Daily Management Plan

1. This student wears a "Medic Alert": Yes _____ No _____
2. Daily medication:
   Name of medication: _____ Dosage: _____ Time(s) of day: _____
   Name of medication: _____Dosage: _____ Time(s) of day: _____
   Name of medication: _____Dosage: _____ Time(s) of day: _____
3. Pain Medication:
   Name of medication: _____ Dosage: _____ Time(s) of day: _____
   Name of medication: _____ Dosage: _____ Time(s) of day: _____

4. This student CAN NOT participate in the following activities:
   _____
5. Activities that bring on a pain crisis:
   _____
6. This student has been hospitalized for pain crisis: Yes _____ No _____
   Dates of Hospitalization for pain crisis: _____

Please note: If medications are to be taken at school, a Medication Authorization form must be completed by a physician.

Parent/Guardian Signature: _____ Date: _____

School Health Officer Signature: _____ Review Date: _____

THIS INFORMATION WILL BE SHARED WITH APPROPRIATE SCHOOL STAFF UNLESS OTHERWISE STATED