

Place

Student’s Picture

Here

**Sickle Cell Disease Action Plan**

**To be completed by Healthcare Provider**

Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_

Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Classroom: \_\_\_\_\_\_\_\_\_School Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Healthcare Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREVENTION MEASURES:**

* Allow child to stop exercises, physical activity without undue attention
* Allow adequate fluid intake throughout the school day along with access to the bathroom
* Reduce exposure to extreme hot or cold environmental temperatures
* Ice must not be used for injuries
* Administer medication as prescribed by the healthcare provider, allowing student to rest until medication takes effect
* Reduce exposure to communicable disease
* Promote hand washing

**RECOGNITION OF SYMPTOMS (PAINFUL EPISODE). CONTACT PARENT GUARDIAN IF:**

* Pain in the hands or feet
* Bone pain in the arms, legs, back, and/or chest
* Abdominal pain
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SEEK MEDICAL CARE** | **SEEK EMERGENCY CARE** |
| * Rapid heart beat * Joint swelling * Headache * Yellowing of the skin * Severe pain * Increased body temperature * Paleness * Visual disturbances * Cough * Loss of balance * Change in behavior * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Pain Crisis * Sudden change in vision * Slurring of speech * Weakness in legs or arms * Change in mental status * Seizure * Chest pain * Stroke like symptoms * Difficulty breathing * Lethargy * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Emergency Contacts:**

|  |  |  |
| --- | --- | --- |
| **Name/Relationship** | **Phone Number** | **Alternate phone number** |
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Healthcare Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name/Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_