



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: \_\_\_\_\_

SEEK MEDICAL CARE	SEEK EMERGENCY CARE
<input type="checkbox"/> Rapid heartbeat <input type="checkbox"/> Joint swelling <input type="checkbox"/> Headache <input type="checkbox"/> Yellowing of the skin <input type="checkbox"/> Severe pain <input type="checkbox"/> Increased body temperature <input type="checkbox"/> Paleness <input type="checkbox"/> Visual disturbances <input type="checkbox"/> Cough <input type="checkbox"/> Loss of balance <input type="checkbox"/> Change in behavior <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pain Crisis <input type="checkbox"/> Sudden change in vision <input type="checkbox"/> Slurring of speech <input type="checkbox"/> Weakness in legs or arms <input type="checkbox"/> Change in mental status <input type="checkbox"/> Seizure <input type="checkbox"/> Chest pain <input type="checkbox"/> Stroke like symptoms <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Lethargy <input type="checkbox"/> Other: _____

#### Emergency Contacts:

Name/Relationship	Phone Number	Alternate phone number

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