Florida Department of Health in Miami-Dade County
School Health Program
Health History and Consent: Sickle Cell Disease

Student: _____DOB: _____ Teacher: _____ Grade: _____
School: _____ Parent/Guardian & Phone(s): _____
Physician & Phone: _____ School Year: _____
KNOWN ALLERGIES: _____

Dear Parent/Guardian:
School records or medical information indicates your child has sickle cell. In order to attend to your child's health and safety, the school requires a health history. Please return this form to the nurse as soon as possible. It will become part of your child's confidential school health record. Our primary concern is that your child's healthcare needs are met while in school.

_____	_____	_____
School Nurse	Phone number	Date

1. What age was your child when diagnosed with sickle cell disease? _____
2. Has your child experienced any complications related to sickle cell disease? (☑ All that apply)

   ☐ Frequent kidney infections ☐ Lung infections (chest pain, cough, difficulty breathing, and fever) ☐ Seizures
   ☐ Heart problems (systolic murmurs) ☐ Skin problems (ulcers, skin sores) ☐ Anemia (pallor, jaundice, fatigue)
   ☐ Gallbladder problems (gallstones) ☐ Bone and joint problems (pain episodes) ☐ Eye problems
   ☐ Other, please explain:
   _____

3. Has your child ever been hospitalized for a sickle cell crisis? ☐ No ☐ Yes If yes, last hospitalization date? _____
4. Please list the medications your child takes for sickle cell disease:

Name of Medication	**Dosage**	**Frequency/Time**

5. List any other medications your child takes.

Name of Medication	**Dosage**	**Frequency/Time**

6. List any side effects from the above medication(s) your child experienced? _____
7. Self care: Does your child know:

How to identify sickle cell triggers (what causes sickle cell crisis)?	Yes	No
The warning signs of sickle cell crisis?	Yes	No
What medication to take?	Yes	No
To tell an adult if not feeling well?	Yes	No

8. Additional comments: _____

CONSENT

Please circle your response and sign: (**I do /I do not**) give the school nurse my permission to share information relevant to my child's medical status with school staff on a "need to know" basis, if it is determined that this information is necessary to assure my child's health and safety.

Parent/Guardian Signature: _____ Date: _____