TO BE MAINTAINED IN PERMANENT RECORD. DO NOT DESTROY.

Sickle Cell Disease
Health Care Plan for School/Field Trips

Name of Student:____ Date of Birth: ___________________

Dear Parent:
We understand that your child has Sickle Cell Disease. Please complete this form and return it to school. If your child needs medication at school, we must have a completed medication authorization form. It is your responsibility to inform school staff regarding your child's medical needs. This Care Plan will be maintained on file for your student. If changes are needed to this Care Plan, please notify your School Nurse.

____

School Nurse Phone

____

Symptoms of your child's sickle cell crisis may include (please circle):

- pale or jaundice color
- shortness of breath/cough
- difficulty with speech or vision
- decreased energy level
- paralysis and/or seizure
- pain in legs, arms, back, chest or abdomen
- fever
- confusion

Date of last crisis _______________ Date of last hospitalization for SCD ______________________
Medication prescribed for pain relief ____
Parents' Comments ____
____

If at some future date any of this information changes, please notify the school. Please sign below, indicating your consent for me to communicate with Dr.__________________________________.

Parent/Guardian Signature____**Date**________________
Telephone (home)________________________________**(work)**___________________________________

Intervention by School Staff for Student Experiencing Acute Symptoms:

- Notify parent.
- Support and reassure student; allow student to rest.
- Give pain medication, if ordered.
- Encourage fluids.
- Allow extra bathroom breaks as needed.
- Encourage students to participate in activities to their level of tolerance.
- **DO NOT APPLY ICE TO SWELLING OR INJURIES.**

Teachers are responsible for establishing a means of notifying all others who may assume responsibility for this student (teacher assistants, substitute teachers, specialty teachers), that this plan exists.
Date Completed __________________________