Mecklenburg County Health Department School Health Program

SICKLE CELL EMERGENCY ACTION PLAN

| Na | ıme: | Allergies: | | | | | | |
|------------------|---|----------------------------|----------------------------|-----------------------|-------|--|--|--|
| School: | | Year: | Grade: | Grade: Date of Birth: | | | | |
| Hor | meroom Teacher: | Room: | Student ID #: | | | | | |
| | | | Ph | Ph. (H) | | | | |
| | | | Ph. (W) | | | | | |
| | | Ph. (H) | | | | | | |
| | | | Ph. (W) | | | | | |
| | nergency Phone Contact #1 | | | | | | | |
| 2 | Nam | | | onship | Phone | | | |
| Em | nergency Phone Contact #2 | | | 1 | | | | |
| | Nam | | | | Phone | | | |
| Phy | ysician treating student for Sickle Cell: | | | Ph.: | | | | |
| Other Physician: | | | | Ph.: | | | | |
| ות | MERGENCY PLAN (Fill | | | 10 11 1 | | | | |
| | | l in blanks, cross out and | initial any steps not need | ed for this studei | nt.) | | | |
| 1. | Early warning signs of crisis: | ioint | | | | | | |
| | Joint pain, swelling or warmth in joint | | | | | | | |
| | • Fatigue | | | | | | | |
| | • Fever (greater that 101°) | | | | | | | |
| | Headache | | | | | | | |
| | Onset of pale color (pale fingernail beds, tissue around eyes) | | | | | | | |
| | • Other: | | | | | | | |
| 2. | Steps to take if early warning signs | s occur: | | | | | | |
| | Allow to rest | | | | | | | |
| | _ | • Encourage fluids | | | | | | |
| | | Contact parent/guardian | | | | | | |
| _ | • Other: | | | | | | | |
| 3. | g j | en the student has | symptoms such a | s: | | | | |
| | Severe generalized pain | | | | | | | |
| | Severe headache | • | | | | | | |
| | One sided weakness, slurred specifications | ech | | | | | | |
| | Abnormal behavior Profile to the second secon | | | | | | | |
| | • Difficulty waking up, listless | | | | | | | |
| | Sudden significant cough Chest pair | | | | | | | |
| | Chest pain Abdominal swelling, abdominal pain | | | | | | | |
| | | • | | | | | | |
| 4. | • Other: Steps to take during a Sickle Cell c | | | | | | | |
| →. | Contact parent/guardian or doctor | | | | | | | |
| | Encourage fluids, if alert | | | | | | | |
| | Call 911 and transport to | | Hospital | | | | | |
| | • Other: | | | | | | | |

7/09 lp

| Daily | Management Plan: | | | | | | | |
|---------|--|--------------|--------------------|--------------------------|--|--|--|--|
| 1. | Does your child wear a "Medic Alert"? Yes (This is highly recommended) | | No | | | | | |
| 2. | What medication is child currently taking? | | | | | | | |
| | Name: | Amount: | | Time of Day: | | | | |
| | Name: | _ Amount: _ | | Time of Day: | | | | |
| 3. | Is there any medication taken for pain? Yes | S | No | _ | | | | |
| | Name: | _ Amount: _ | | Time of Day: | | | | |
| 4. | Are there activities that your child CAN NOT participate in? | | | | | | | |
| 5. | Are there activities that bring on a pain crisis | | | | | | | |
| 6. | Has your child ever been hospitalized for crisis? If so, when? | | | | | | | |
| | SE NOTE: If medications are to be taken at school, arent and physician and kept at the school. | a Medication | n Authorization fo | orm must be completed by | | | | |
| Parent/ | Guardian Signature: | | | Date: | | | | |
| School | Nurse Signature: | | Date: | | | | | |

This information will be shared with appropriate school staff unless you state otherwise.

7/09 lp CI 25