Sickle Cell Disease: Emergency Care Plan

School Year: ______________

Student Name: ______________ DOB: ______________ Teacher/Grade: ______________

Parent/Guardian: ______________ Contact number: ______________

Healthcare provider: ______________ Contact number: ______________

Preferred hospital: ______________

Sickle cell type: ☐ Sickle cell trait ☐ HbSS ☐ HbSC ☐ HbS beta thalassemia ☐ HbSD ☐ HbSE ☐ HbSO

Hospitalization has been required for SCD: ☐ Yes ☐ No **Date of last admission**: ______________

Current medication(s) / Dose ______________

Student triggers : ☐ Stress ☐ Dehydration ☐ Lack of sleep ☐ Caffeine ☐ Exertion/ Extreme physical activity

☐ Heat above ________ °F ☐ Cold below ________ °F ☐ Other ______________

Description of student-specific symptoms when a VOC/pain crisis occurs:

____

☐ Student is able to recognize signs and symptoms of SCD crisis ☐ Physical education activity restrictions ☐ Ice pack used for injury

SYMPTOMS	ACTION
Bone pain, Headache Joint pain, Fatigue Hip pain, Irritability	⇒ Notify school nurse ⇒ Administer pain medication as ordered ⇒ Allow student to rest and access to water ⇒ Adjust temperature conditions, if appropriate
Temperature > ________ ° F	⇒ Notify school nurse ⇒ Administer medication as ordered ⇒ Call parent
Temperature ≥ ________ ° F	⇒ Notify school nurse ⇒ **Call 911** ⇒ Administer medication as ordered ⇒ Call parent
Sudden onset of severe headache, Inability to speak Change in alertness/confusion, Weakness Sudden or constant dizziness, Change in breathing Difficulty breathing, Pale complexion Stomach pain or swelling	⇒ Notify school nurse ⇒ **Call 911** ⇒ Administer medication as ordered ⇒ Call parent

Healthcare provider's signature: ______________ Date: ______________

School nurse signature: ______________ Date: ______________

I have received and acknowledge training on this student's sickle cell emergency care plan.

Printed name: ______________ Signature: ______________ Date: ______________