Sickle Cell Action Plan

Office Use Only
☐ Uploaded to Synergy Documents
☐ Synergy (2)
☐ Notify RN, copy sent via pony
Initials/date_____

Student Name _____ DOB _____/_____/_____

Building_____ Grade_____ School Year_____/_____

Symptoms	Action
Pain in extremities (hands, feet, legs, arms) Bone pain Abdominal pain	Give acetaminophen (must be prescribed for pain)** Encourage increased fluids: 8 oz per hour Stop activity, allow rest Return to class if pain is controlled, call parents if not
Fever over _____degrees Fahrenheit	Give acetaminophen (must be prescribed for fever)** Encourage fluids: 8 oz per hour Notify parent to seek medical evaluation
Combination of: Cough, chest pain, bone pain, fever	Notify parent to seek medical evaluation Anticipate child to be absent, arrange for school work
Urinary frequency	Allow unrestricted bathroom use Encourage/allow extra fluids, water bottle
Stroke symptoms: loss of balance, falls, weakness on one side, change in walk, severe headache, visual changes, changes in behavior, first seizure, slurred speech, facial droop	Call **9-1-1** Call MERT team Call parent Stay with student until emergency responders arrive
Pale or yellowing skin, nail beds, eyes Excessive tiredness	Notify parent to seek medical evaluation
Combination of: Pale, tired, swelling in extremities, pain in abdomen, sweating	Call **9-1-1** Call MERT team Call parent Stay with student until emergency responders arrive

Other symptoms and actions to be taken_____

_____

Physician Signature_____ Date_____

Physician Name_____ Phone_____

I have reviewed this plan with my child's physician. I give Carman-Ainsworth school staff permission to treat my child according to this plan. I understand this information will be shared with school staff members who may need to know this information to maintain my child's health and safety. I will update the school with any changes to my child's plan. I give permission for exchange of verbal and written communication between the physician and the school nurse and/or designated school staff regarding this plan. I understand emergency services may be called if symptoms arise and prefer my child to go to (hospital) _____ if possible.

Parent/Guardian Signature_____ Date _____

Parent/Guardian Name_____ Phone_____

**Must also fill out Medication Authorization Form(s) if medication is to be taken at school.

Updated/Reviewed 12/21, SK