

Fulton Science Academy

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 ☐ HbSOHospitalization 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	⇒ Notify school nurse
Joint pain	Fatigue	⇒ Administer pain medication as ordered
Hip pain	Irritability	⇒ 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	⇒ Notify school nurse
Change in alertness/confusion	Weakness	⇒ Call 911
Sudden or constant dizziness	Change in breathing	⇒ Administer medication as ordered
Difficulty breathing	Pale complexion	⇒ Call parent
Stomach pain or swelling		

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: _____