BEDFORD CITY SCHOOL DISTRICT
PROUDLY SERVING BEDFORD • BEDFORD HTS. • WALTON HILLS • OAKWOOD

Sickle Cell Disease Action Plan

School Year 20___-20___

Student Information: **School:** _____

Name of Child:_____ Date of Birth: _____

Grade/Child's Age:_____ Homeroom Teacher: _____

Emergency Information:

Parent(s') or Guardian(s') Names: _____

Mother or Guardian #1 Name: _____ Father or guardian #2 Name: _____

Mother or Guardian #1 contact number: _____ Father or guardian #2 Contact Number: _____

Mother's or Guardian #1 second number:_____ Father or guardian #2 second number: _____

Child's Healthcare Provider: _____ Healthcare Provider Telephone: _____

Please provide emergency contact information in the event a parent/guardian cannot be reached:

1:_____ Relation:_____ Telephone: _____

2:_____ Relation:_____ Telephone: _____

Preferred Local Emergency Department: _____

Signs and symptoms that might indicate child is becoming ill:

Symptoms may be brought about by infection, stress, dehydration, strenuous exercise and cold.

* Rapid Heart Beat
* Joint Swelling
* Headache
* Fever
* Increased Jaundice
* Severe Pain
* Pain
* Increased Pallor
* Difficulty Breathing
* Chest Pain
* Other: _____

My child has the following other chronic illnesses/disabilities: _____

_____

Allergies:_____

_____

Child's Limitations or Special Considerations for school to consider:

[ ] Requires extra water for physical education

[ ] Allow frequent bathroom breaks

[ ] Allow child to stop exercises, physical activity without undue attention

[ ] Requires access to water

Other _____

_____

LIST ALL CURRENT MEDICATIONS

(An A*uthorization to Administer Medication* in school form is required for any medications to be administered during the school day. Please have your child's healthcare provider complete and sign the Authorization form if medications are required at school.)

Name of Medication	Dosage and Strength	Purpose	Day Schedule	Time of Day

I understand that it is my responsibility to keep this information current.

Please notify the School Nurse if any changes occur during the school year. This form must be updated for each school year.

Parent's/ Guardian's Signature: _____ Date: _____

Child's Name _____ Date of Birth:_____

Sickle Cell Disease
Action Plan

SICKLE CELL EMERGENCIES:

FEVER

∉ Temperature > 101°F.

♦ Call parent/guardian. If parent/guardian cannot be reached within _____ minutes, call 911.

♦ Other:

Acute Chest Syndrome:

- Fast or difficult breathing
- Chest pain
- Fever
- Cough
- Blue color to lips and mouth area

♦ Call 9-1-1

♦ Notify parent/guardian.

STROKE:

- Sudden and Severe headache
- Seizure
- Sudden change in vision
- Slurring of speech
- Weakness in limb
- Change in mental status

♦ Call 9-1-1

♦ Notify parent/guardian.

Pain:

∉ Change in level of pain

∉ a ŠŘλÔI·ûλ2yã ótfŜI·åŜ Ô2Y˙LJfŜûŜ I·ûűI·ŎKŜŘ ŦƵℕY˙ù

♦ Inform parent if signs and symptoms are not imLJℕ2ØŜŘ after _____minutes ƶℕ ƛŦ ψψψψψψψψψψψψψψψψψψψψψψ

Other:_____

Other considerations/special care for the school setting/school sponsored activities:

_____

_____

_____

_____

List Medical History:

_____

_____

_____

_____

Special Individual Instructions:

[ ] Requires frequent hydration for physical education.
[ ] Requires access to water through out the day.
[ ] Water bottle on hand throughout school day
[ ] Allow frequent bathroom breaks
[ ] Allow child to stop exercise, physical activity without undue attention.
Other: _____

_____

_____

Medical Provider's Name: _____ Phone number: _____
Medical Provider's Signature: _____ Date: _____
School Nurse: _____ Contact Number: _____

BEDFORD CITY SCHOOL DISTRICT

PROUDLY SERVING BEDFORD • BEDFORD HTS. • WALTON HILLS • OAKWOOD

AUTHORIZATION TO ADMINISTER MEDICATION

Student Name:_______________________________________ Date of Birth: _______ Grade: ____ Teacher:__________ School: ___________________

THIS SECTION IS **TO BE COMPLETED BY THE HEALTH CARE PROVIDER** *Please print clearly and complete **ALL** sections.*

NAME OF MEDICATION	STRENGTH	DOSE	ROUTE (circle or highlight route)	FREQUENCY (include time of administration for daily medication and include minimum time interval for prn dosing)	DIAGNOSIS	START DATE	STOP DATE
			Tablet/Capsule (oral) Liquid (oral) Inhaler/Nebulizer Other_________	____________________ OR as needed every _____ hours		__/__	__/__ OR END OF SCHOOL YEAR
			Tablet/Capsule (oral) Liquid (oral) Inhaler/Nebulizer Other_________	____________________ OR as needed every _____ hours		__/__	__/__ OR END OF SCHOOL YEAR
			Tablet/Capsule (oral) Liquid (oral) Inhaler/Nebulizer Other_________	____________________ OR as needed every _____ hours		__/__	__/__ OR END OF SCHOOL YEAR

Precautions and/or adverse reactions to report____

Date: _____ Health Care Provider Signature: ______________________________ Health Care Provider Name ________________________

Address______________________________________ Phone Number: ___________________ Fax Number: ___________________

TO BE COMPLETED BY PARENT OR GUARDIAN: I give my permission for (Name of child)__________________________) to receive the medications listed above at school or during school events according to the school policy. The school nurse (or other school personnel) involved with the supervision of my child's health, has my permission to exchange health information with the health care provider. For the safety of my child and all other children I have read and agree to adhere to the school policy regarding medications at school. I understand that the school district and any of its personnel are absolved from any civil liability, which might be associated with the medication assistance.

Parent/Guardian Signature: ___________________________ Parent/Guardian Name: ____________________ Date: ___________

Parent/Guardian Phone Numbers: Cell _________________ Home_______________Work______________ Other ___________

Please note: *Medication must be delivered to school by a parent or guardian in the container in which it was dispensed by the prescribing health care provider, licensed pharmacist or pharmacy. If the medication or dosage is changed, a new form must be completed.* ***THIS FORM MUST BE COMPLETED EVERY SCHOOL YEAR.***

TO BE COMPLETED BY SCHOOL: Date received at school: _________ School Nurse Signature:_______________________