Muscogee County School District
Student Health Services
SICKLE CELL DISEASE STUDENT HEALTH CARE PLAN

Please mail or return to the school clinic.

A new health care plan is required every school year.

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Student: _____Date of Birth: _____School year: _____

School: _____Teacher: _____Grade/Team: _____

Emergency Contacts

Parent/Guardian/Contact	Relationship	Phone Number	Alternate Phone Number
Primary Healthcare Provider:		**Phone Number:**	

SCHOOL TIPS to PREVENT/DECREASE SICKLE CELL EVENTS

- Maintain adequate hydration (carry water bottle)
- Exercise based on tolerance
- Avoid extremes in hot/cold temperatures, dress appropriately for weather.
- Staff awareness of signs/symptoms and management of sickle cell event.

Please check symptoms that child may present during a sickle cell event or crisis.

- ☐ Pain Locations: _____
- ☐ Fever Notify Parent/Guardian if temperature is above _____
- ☐ Fatigue / Weakness
- ☐ Pale or jaundiced colored skin
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Unusual Behavior
- ☐ Refusal to Eat or Drink
- ☐ Increased Heart Rate

Management of Symptoms

Possible Symptoms	Action to Take
Fatigue	☐ Exercise based on tolerance ☐ Allow rest as needed
Pain: mild to moderate (arms, legs, chest, abdomen)	☐ Stop activity and rest ☐ Give fluids/ allow to carry water bottle ☐ Warm compresses to site, if helpful ☐ Medication : _____ ☐ Notify Parents ☐ Loosen tight or restrictive clothing
Severe Pain, swollen and painful abdomen, pallor, extreme tiredness, vomiting or diarrhea	☐ **CALL PARENT AND SEEK IMMEDIATE MEDICAL ATTENTION**
Fever	☐ Call parent ☐ If over 101, send home/remain in clinic ☐ Give fluids

2/2018
School Nurses Sharepoint Document Location: Forums > Care Plans

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Pain Management

√ Given at school	Medication Name	Dosage(amount)/Time	When to use

Comments and Special Instructions (including school activities, sports, field trips, etc):

Physician's Authorization

My signature provides for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

- If changes are indicated, I will provide new written authorized orders
- Dose/treatment changes may be relayed through parent/guardian.

Physician's Name: _____ Phone Number: _____

Physician's Signature: _____ Date: _____

Parent Consent for Management of Health Condition at School

I _____(Parent/Guardian) hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Nurse and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's health condition and for this information to be shared with pertinent school staff at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portable and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Muscogee County Schools. This authorization expires as of the last day of the school year.

I request designated school personnel to administer the medication and treatment orders as prescribed above. I agree to provide the necessary supplies and equipment and to notify the school nurse if there is a change in the student's health management or health care provider.

I understand that it is my responsibility to notify the bus driver, school administration, teacher, clinic worker and school nurse of any and all health conditions for my child.

Parent/Guardian's Signature: _____ Date: _____