Mecklenburg County Health Department
School Health Program

SICKLE CELL EMERGENCY ACTION PLAN

Name: _____Allergies: _____

School: _____ Year: _____ Grade: _____ Date of Birth: _____

Homeroom Teacher: _____ Room: _____ Student ID #: _____

Parent/Guardian: _____ Ph. (H) _____

Address: _____ Ph. (W) _____

Parent/Guardian: _____ Ph. (H) _____

Address: _____ Ph. (W) _____

Emergency Phone Contact #1 _____ _____ _____

Name Relationship Phone

Emergency Phone Contact #2 _____ _____ _____

Name Relationship Phone

Physician treating student for Sickle Cell: _____ Ph.: _____

Other Physician: _____ Ph.: _____

EMERGENCY PLAN

(Fill in blanks, cross out and initial any steps not needed for this student.)

1. **Early warning signs of crisis:**
   - Joint pain, swelling or warmth in joint
   - Fatigue
   - Fever (greater that 101)
   - Headache
   - Onset of pale color (pale fingernail beds, tissue around eyes)
   - Other: _____
2. **Steps to take if early warning signs occur:**
   - Allow to rest
   - Encourage fluids
   - Contact parent/guardian
   - Other: _____
3. **Emergency action is necessary when the student has symptoms such as:**
   - Severe generalized pain
   - Severe headache
   - One sided weakness, slurred speech
   - Abnormal behavior
   - Difficulty waking up, listless
   - Sudden significant cough
   - Chest pain
   - Abdominal swelling, abdominal pain
   - Other: _____
4. **Steps to take during a Sickle Cell crisis:**
   - Contact parent/guardian or doctor's office
   - Encourage fluids, if alert
   - Call 911 and transport to _____ Hospital
   - Other: _____

Daily Management Plan:

1. Does your child wear a "Medic Alert"? Yes _____ No _____
   (This is highly recommended)

2. What medication is child currently taking?

   Name: _____ Amount: _____ Time of Day: _____

   Name: _____ Amount: _____ Time of Day: _____

3. Is there any medication taken for pain? Yes _____ No _____

   Name: _____ Amount: _____ Time of Day: _____

4. Are there activities that your child CAN NOT participate in? _____

   _____

5. Are there activities that bring on a pain crisis? Briefly describe. _____

   _____

6. Has your child ever been hospitalized for crisis? If so, when? _____

   _____

*** PLEASE NOTE: If medications are to be taken at school, a Medication Authorization form must be completed by the parent and physician and kept at the school.**

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

This information will be shared with appropriate school staff unless you state otherwise.