

**Mecklenburg County Health Department
School Health Program**

SICKLE CELL EMERGENCY ACTION PLAN

Name: _____ Allergies: _____

School: **Elizabeth Lane Elementary** 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
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Emergency Phone Contact #2 _____

	Name	Relationship	Phone
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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 than 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.