



Sickle Cell Action Plan

Student Name _____ DOB ____/____/____

Building _____ Grade _____ School Year ____/____

Symptoms	Action
Pain in extremities (hands, feet, legs, arms) Bone pain Abdominal pain	Give acetaminophen (must be prescribed for pain)** Encourage increased fluids: 8 oz per hour Stop activity, allow rest Return to class if pain is controlled, call parents if not
Fever over _____degrees Fahrenheit	Give acetaminophen (must be prescribed for fever)** Encourage fluids: 8 oz per hour Notify parent to seek medical evaluation
Combination of: Cough, chest pain, bone pain, fever	Notify parent to seek medical evaluation Anticipate child to be absent, arrange for school work
Urinary frequency	Allow unrestricted bathroom use Encourage/allow extra fluids, water bottle
Stroke symptoms: loss of balance, falls, weakness on one side, change in walk, severe headache, visual changes, changes in behavior, first seizure, slurred speech, facial droop	Call 9-1-1 Call MERT team Call parent Stay with student until emergency responders arrive
Pale or yellowing skin, nail beds, eyes Excessive tiredness	Notify parent to seek medical evaluation
Combination of: Pale, tired, swelling in extremities, pain in abdomen, sweating	Call 9-1-1 Call MERT team Call parent Stay with student until emergency responders arrive

Other symptoms and actions to be taken _____

Physician Signature _____ Date _____

Physician Name _____ Phone _____

I give permission for Carman-Ainsworth Schools to treat my child _____ according to the plan above. I understand emergency services may be called if symptoms arise and prefer my child to go to (hospital) _____ if possible.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Name _____ Phone _____