

School Year

20__-20__

Jackson-Madison County School System Sickle Cell Anemia-Age Specific Form ≥5 Years of Age

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Page 1 to be completed
by Parent/Guardian

Child's Information:

School: _____

Name of Child: _____ Date of Birth: _____

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

Physical Education Days and Times: _____

Emergency Information:

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

Mother's or Guardian(s) Telephone (W): _____ Father's Telephone (W): _____

Mother's or Guardian(s) Cell/Pager: _____ Father's Cell/Pager: _____

Mother's or Guardian(s) Telephone (H): _____ Father's Telephone (H): _____

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

Child's Neurologist: _____ Neurologist's Telephone: _____

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

1: _____ Relation: _____ Telephone: _____

2: _____ Relation: _____ Telephone: _____

Preferred Local Emergency Department: _____

Preferred Comprehensive Regional Pediatric Center:

Jackson-Madison Co. General Hospital Le Bonheur- Memphis Tennova- Regional Vanderbilt- Nashville

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
* 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:

Requires extra water for physical education Allow frequent bathroom breaks

Allow child to stop exercises, physical activity without undue attention Requires access to water

Pneumococcal vaccine series has been completed: Yes No

Other _____

ALL CURRENT MEDICATIONS

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 and provide an updated/current form on at least an annual basis.**

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

Jackson-Madison County School System Sickle Cell Anemia-Age Specific Form 5-10 Years of Age

SICKLE CELL EMERGENCIES:

<p><u>FEVER</u></p> <ul style="list-style-type: none"> ● Temperature > 101°F. ◆ Call Parents. <p><u>Acute Chest Syndrome:</u></p> <ul style="list-style-type: none"> ● Fast or difficult breathing ● Chest pain ● Fever ● Cough ● Blue color to lips and mouth area: ◆ Call 9-1-1 ◆ Notify response person in building. 	<p><u>STROKE:</u></p> <ul style="list-style-type: none"> ● 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 <p><u>Pain Crisis:</u></p> <ul style="list-style-type: none"> ● Change in level of pain ● Fever: [] Administer Tylenol [] Administer Motrin ◆ Inform parent if signs and symptoms are not improved after _____ minutes.
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Preferred Local Emergency Department: _____

Preferred Comprehensive Regional Pediatric Center:

[] Jackson-Madison Co. General Hospital [] Le Bonheur– Memphis [] Tennova– Regional [] Vanderbilt– Nashville

IT IS THE PARENT'S RESPONSIBILITY TO DETERMINE FOLLOW-UP CARE FOR SYMPTOMS.

List Medical History

Special Individual Instructions:

- [] Requires frequent hydration for physical education.
- [] Requires access to water through out the day.
- [] Fluid intake during school hours ____ quarts every 2 hours.
This may necessitate child having water bottle on hand.
- [] Allow frequent bathroom breaks (every 2 hours or _____)
- [] Allow child to stop exercise, physical activity without undue attention.

Other _____

This child also has the following chronic illnesses/disabilities: _____

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