The Brook Hill School
Christ-Centered. College Prep.

INDIVIDUAL HEALTH PLAN SICKLE CELL ANEMIA

Student:	**Date of Birth:**	
Medication Allergies:	**Food Allergies:**	
Current Medications:		
EMERGENCY CONTACTS		
Home Phone:	**Mother Cell:**	**Father Cell:**
Physician PCP Name & #:		
Physician Specialist Name & #:		
Hospital of Choice:		
Call 911 when:		

Type of Sickle Cell Anemia: SS Sickle Cell Anemia ____ SC: Sickle Hemoglobin_____

ST: Sickle Beta-Plus Thalassemia and Sickle Beta-Zero Thalassemia _____

Blood Type: _____ Transfusion Consent: Yes_____ No_____

Special Needs during School Hours:

1. Rest Periods: As Needed _____ Specify _____++++_____
2. Unlimited Access to fluids, especially during PE or Athletics
3. Unlimited bathroom pass
4. Physical Activity Restrictions: None _____ Specify _____
5. If a pain crisis occurs:
   a. _____ Administer pain medication Specify_____
   b. _____ Apply moist heat to affected area
   c. _____ Contact parents immediately
6. Special needs for field trips, excursions or trips away from campus
   _____
   _____
7. Special Needs for swimming or water activities
   _____
8. Call parent when: _____
9. _____ Additional Instructions Attached

Physician Signature: _____ Date: _____

Parent Signature: _____Date: _____