Child's Name:_____

HEAD START

Tri-County Community Council, Inc.
2499 Cypress St. Westville, Fl 32464
(850) 548-9900 FAX (850) 548-5644

SICKLE CELL ANEMIA

Child Information Center:_____
Name of Child:_____ Date of Birth:_____
Child's Age:_____ Classroom Teacher:_____
Emergency Information
Parent(s') or Guardian(s') Names:_____
Mother's Telephone (H):_____ Father's Telephone (H):_____
Pager:_____ Pager:_____
Telephone (W):_____ Telephone (W):_____
Hematologist:_____ Telephone:_____
Primary Care Physician:_____ Telephone:_____
Preferred Local Emergency Department:_____
In the event a parent/guardian cannot be reached:
1._____ Relation:_____ Telephone:_____
2._____ Relation:_____ Telephone:_____

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
- ☐ Increased jaundice
- ☐ Increased pallor
- ☐ Chest pain
- ☐ Joint swelling
- ☐ Severe pain
- ☐ Difficulty breathing
- ☐ Headache
- ☐ Fever
- ☐ Other:_____

My child has the following chronic illnesses/disabilities:

_____
_____

Allergies:

_____
_____

Child's Limitations or Special Considerations:

- ☐ Requires extra water for physical activity.
- ☐ Allow child to stop physical activity without undue attention.
- ☐ Requires access to water.
- ☐ Allow frequent bathroom breaks.
- ☐ 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 Center Coordinator and provide an updated/current form on at least an annual basis.

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

Child's Name: _____

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SICKLE CELL ANEMIA

Sickle Cell Emergencies

Fever
- Temperature ≥ 101 F: Call parent.

Acute Chest Syndrome
- Fast or difficult breathing
- Chest pain
- Fever
- Cough
- Blue color to lips and mouth area: Call 911. Notify response person in building. Notify parent.

Stroke
- Sudden and severe headache: Inform parent. If accompanied by following signs and symptoms, call 911.
- Seizure
- Sudden change in vision
- Slurring of speech
- Weakness in limb
- Change in mental status

Pain Crisis
- Change in level of pain
- Fever
  Administer Tylenol_____
  Administer Motrin _____
  Inform parent if signs and symptoms not improved after _____minutes.

Preferred Local Emergency Department:_____

It is the parent's responsibility to determine follow-up care for symptoms.

Past Medical History:_____
_____
_____
_____

Special Individual Instructions:

☐ Requires frequent hydration.
☐ Requires access to water throughout 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 physical activity without undue attention.
☐ Other:_____
_____
_____

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

Physician's name:_____
Physician's signature:_____ Date:_____