School Year:

# Sickle Cell Disease: Emergency Care Plan

Student Name: _____ DOB: _____ School: _____

Parent/Guardian: _____ Contact Number: _____

Healthcare Provider: _____ Contact Number: _____

Preferred Hospital: _____

**Sickle Cell Type:** ☐ Sickle Cell Trait ☐ HbSS ☐ HbSC ☐ HbS beta thalassemia ☐ HbSD ☐ HbSE ☐ HbSO

**Has hospitalization been required for SCD**: ☐ Yes ☐ No **Date of last admission:** _____

**Current medication(s)/Dose:**

_____

_____

_____

**Student triggers:** ☐ Stress ☐ Dehydration ☐ Lack of sleep ☐ Caffeine ☐ Exertion/Extreme physical activity

☐ Heat above _____degrees F ☐ Heat below _____degrees F ☐ Other: _____

**Description of student-specific symptoms when a vaso-occlusive crisis or pain crisis occurs:**

_____

_____

☐ Student is able to recognize signs and symptoms of SCD crisis ☐ Physical education activity restrictions
☐ Ice pack allowed for injuries

| SYMPTOMS | ACTION |
|---|---|
| Bone Pain<br>Headache<br>Joint Pain<br>Fatigue<br>Hip Pain<br>Irritability | • Notify parent/guardian<br>• Administer pain medications as ordered<br>• Allow student to rest and access to water<br>• Adjust temperature conditions, if appropriate |
| Temperature greater than _____ degrees F | • Notify parent/guardian<br>• Notify school nurse<br>• Administer medication as ordered |
| Temperature greater than _____ degrees F | • Call MERT team and 911<br>• Call school nurse<br>• Administer medication as ordered (if able to take)<br>• Call parent/guardian |
| Sudden onset of severe headache<br>Inability to speak<br>Change in alertness/confusion<br>Weakness<br>Sudden or constant dizziness<br>Change in or difficulty breathing<br>Pale complexion<br>Stomach pain or swelling | • Call MERT team and 911<br>• Call school nurse<br>• Administer medications as ordered (if able to take)<br>• Call parent/guardian |

Healthcare Provider Signature: _____ Date: _____

Parent Signature: _____ Date: _____

# Waverly Community Schools Medication Administration Authorization Form

Michigan State Law requires that school staff administering medications must have written orders from the physician/licensed prescriber and written authorization from the parent/guardian**.**
Parents are urged to give medication at home on a schedule outside of school hours, if possible. If it is necessary that medication be provided during school hours, these regulations must be followed:

- All prescription medications must have a written order from a physician or other licensed prescriber and must be renewed every year or with any changes. Any medication that is a controlled substance must be renewed every 30 days or with any changes.
- All medication must be brought to school in the original pharmacy or OTC container labeled with the name of the student, medication, strength, dosage, route, and time(s) to be given. The parent/guardian is expected to deliver the medication to the school. Students are not allowed to bring their own medication to school.
- Medications and related equipment/supplies, as ordered, must be provided to the school by parent/guardian as needed.
- A separate authorization form must be completed for each medication that will be administered throughout the school day.

**STUDENT'S NAME: _____ DATE OF BIRTH: _____**

**SCHOOL:_____**

***TO BE COMPLETED BY THE PHYSICIAN:***

| Medication Name | Dosage | Route | Frequency and Time |
|---|---|---|---|
| | | | |

| | |
|---|---|
| **Form of Medication**: ☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Other: | |
| **Diagnosis:** | |
| **Special instructions/storage requirements:** | |
| **Restrictions and/or important side effects:** | |
| **Is student able to self-carry this medication?** ☐ Yes ☐ No | |
| **Order start date:** | **Order end date:** |
| *(If no end date is indicated, medication orders will expire at the end of the current school year).* | |
| **Prescriber signature:** | **Date:** |
| **Printed Name:** | **NPI#:** |
| **Address:** | |
| **Phone:** | **Fax:** |

***TO BE COMPLETED BY THE PARENT/GUARDIAN:***

I hereby give permission for school personnel to exchange this information as necessary, administer medication, and provide care for my child, and to contact the child's physician when deemed necessary. I assume full responsibility for providing the school with all prescribed medications as outlined above and any required medical equipment or devices.

I understand and agree that, pursuant to Public Act 157 of 1971 (MCL 380.1178), when school personnel administer medication to my child in accordance with this authorization, I shall not hold the school district, its employees, or agents liable in any criminal action or for civil damages resulting from the administration of such medication, except as provided by law.

All medications must be picked up by a parent or legal guardian within one (1) week following the student's last day of classes. Any medication not collected within this timeframe will be disposed of in accordance with applicable laws and school district policy.

| Signature: | Relationship: | Date: |
|---|---|---|
| | | |

*Please return completed form to the school office or to the District Nurse*

Revised 01/21/2026