Cc:
☐ Teacher (s)
☐ PE Teacher
Office use only

DOWNEY UNIFIED SCHOOL DISTRICT

Student Services

HEMOPHILIAC CARE PLAN

(Must be completed annually)

School Year_____

Student's Name: _____ D.O.B. _____ School/Grade: _____

School ID #: _____

Emergency Information:

Emergency contact: _____ Relationship: _____

Home Number: _____ Work Number: _____ Cell Number: _____

Physician's name: _____ Physician's Number _____

TO BE COMPLETED BY PHYSICIAN

This is a child with (medical diagnosis):

_____

Signs of a hemophiliac emergency:

- External bleeding from a cut, scrape, or laceration.
- Child reports a bleeding episode.
- Tingling, bubbling pain, stiffness, or decreased motion in any limb.
- Part of the body is swollen or hot to the touch (usually a joint).
- Child appears to favor an arm or leg.
- Child limps.
- Blow to head, neck, abdomen, or extremities.
- Any nosebleed.
- Cut in mouth, bleeding around a tooth.

Steps to be followed in the event of a hemophiliac emergency:

- Follow attached first aid procedures for controlling bleeding in hemophiliac.
- Notify your school nurse at once.
- Call parent / guardian or physician, call 911
- Record each incident on *Daily Log of Treatment Administered at School.*

Special Directions or Limitations applying to the student while at school: (To be completed by Physician and Parent)

1. _____
2. _____
3. _____

_____ Print Name of Physician

_____ **Signature of Physician - REQUIRED**

Office Stamp - REQUIRED

_____ Physician Address

_____ Physician Telephone

_____ Date

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TO BE COMPLETED BY PHYSICIAN

ALL CURRENT MEDICATION(S):

MEDICATION TO BE GIVEN AT SCHOOL: (If Any):

Name of Medication	**Dosage**	**Dose Form** (HFA, Nebulizer, Tab, Liquid, Etc.)	**Time**

Is medication supply for **daily** administration necessary during school hours? **Yes** ☐ **No** ☐

MEDICATION TO BE GIVEN AT HOME (IF ANY):

List all additional Medications given at home:

Name of Medication	**Dosage**	**Dose Form** (HFA, Nebulizer, Tab, Liquid, Etc.)	**Time**

Is medication supply for use in the event of a "**DISASTER"** necessary for school use? **Yes** ☐ **No** ☐

If yes, please provide a 72-hour supply of medication in a properly labeled container. This supply is ONLY to be used in the event of a natural disaster.

_____ _____

Parent/Guardian Signature & Date **Physician Signature & Date** **Office Stamp - REQUIRED**

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PHYSICIAN'S RECOMMENDATION FOR PHYSICAL EDUCATION AND OTHER PHYSICAL ACTIVITES

Dear Physician:
All students enrolled in the public schools participate in physical education activities, which are designed to meet their growth and developmental needs. In addition, many students participate in other types of physical activities such as intramural programs, inter-school athletics, band, etc.

Please provide us with the information listed below so that we can provide appropriate activities for this student.

Student name: _____ **Date of Birth**: _____
School: _____ **I.D. #** _____ **Grade**:_____ **Room#** _____

Diagnosis: _____

Prognosis: _____

Please Check Those Activities to be AVOIDED:

Aerobic Activities

- O Running/Jogging
- O Dance
- O Push-Ups/Chin-Ups
- O Sit-Ups
- O Jumping
- O Gymnastics
- O Swimming
- O Badminton
- O Wrestling
- O Basketball
- O Football
- O Soccer
- O Softball
- O Tennis
- O Volleyball
- O Calisthenics
- O Other: _____

Moderate Activities

- O Golf
- O Modified Ball Activities
- O Light Calisthenics
- O Frisbee
- O Rhythms
- O Climbing on Bars
- O Swinging
- O Walking the Track
- O Other:

Individual Fitness Activities

- O Range of Motion Exercises
- O Shoulder/Chest
- O Upper Back/Torso
- O Lower Back/Buttocks/Hips
- O Legs/Ankles
- O Strength Exercises
- O Neck/Shoulders
- O Arms/Wrist
- O Abdomen
- O Upper/Lower Back
- O Legs/Calves
- O Weight Training
- O Weight Range Use:
- O Upper Body
- O Torso/Abs./Back
- O Lower Back
- O Other: _____

The Above Restricted Program is recommended until: _____
(Estimate in weeks or months)

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First Aid for the Child with Hemophilia:

General Guidelines for Treating Specific Bleeding Episodes that may Occur in School

If a Child: has external bleeding from a cut, scrape or laceration
You Should: Give first aid as you would with any other child:
1. put on gloves
2. clean cut with antiseptic
3. apply firm pressure until bleeding stops
4. apply a band-aid or dressing
5. clean up all blood spills with a 10% solution of bleach and water

If a Child: Has a laceration which requires stitches
You Should:
1. give first aid as you would any other child
2. call the parents to take child to the emergency room

If a Child: Suffers a blow to the head, neck or abdomen
You Should:
1. contact the parents immediately for instructions
2. if parents cannot be reached, contact the hemophilia treatment center or the child's doctor
3. if neither the doctor, the nurse or the parents can be reached, call an ambulance and contact the hospital emergency room

If a Child: Has a typical nose bleed
You Should:
1. put on gloves
2. position child sitting straight ahead with head upright
3. if bleeding has not stopped after 20 minutes call the parents for instructions

If a Child: has any other complaints or injury
You Should:
1. contact the parents for instructions

If a Child:
1. says he's having a bleeding episode
2. complains of tingling, bubbling pain, stiffness or decreased motion in any limb or
3. appears to have a part of the body (usually a joint) swollen or hot to the touch or
4. appears to be favoring an arm or leg more than usual or
5. limps, or refuses to use limb

You Should:
1. contact the parents for instructions
2. while waiting for parents, keep the child still to avoid further injury
3. you may apply an ice pack and elevate the body part

If a Child: Has oozing from a cut in the mouth or around the tooth
You Should:
1. put on gloves
2. apply ice compresses with firm, continuous pressure for 20 minutes
3. a wet tea bag can be applied around a tooth
4. if no response, call parents for instructions
5. clean up all blood spills with a 10% solution of bleach and water

Important Phone Numbers

Child's Name: _____ Grade: _____ Diagnosis: _____

Home Phone: _____ Mother's work: _____ cell: _____

Father's Work: _____ cell: _____ other: _____

Name of Nurse/Doctor at Hemophilia Center: _____ phone # _____

Family Doctor: _____ phone # _____

Nearest ER: _____ phone # _____

Ambulance: _____ Drug allergies: _____

Choice of treatment product : _____

Notes: _____

_____