Hemophilia Action Plan

Name of Student: _____ DOB: _____ Grade/Teacher: _____

Hemophilia is a hereditary disease characterized by bleeding episodes that are either spontaneously or traumatically induced. Each type of hemophilia is caused by the lack of certain clotting factors. Bleeding is the result of the low level of clotting factors.

Symptoms: Tingling or other sensation, limb held in abnormal position, discomfort or pain, area warm to the touch, swelling, firmness and/or tenderness at the site of the bleed, restrictions in movement of the affected limb.

- Joints and muscles are the most common sites of bleeding.
- Any bleeding in the head or neck is a medical emergency (unless it is a nosebleed).

Interventions:

1. Note the location of the bleed and treat all bleeding episodes promptly.
2. Control the bleed by applying pressure to the site for 10 – 15 minutes.
3. Elevate the site above heart level, and apply cold compresses (ice if available).
4. Contact parent and inform them of the bleed.
5. Allow the child to rest while waiting for the parent.
6. Do not give aspirin or any non-steroidal pain medications for pain.
7. If bleeding is *uncontrolled*, or in the head or neck region (except nosebleeds), **call 911 and the Parent/Guardian**.

Additional Instructions: _____

_____

Physical limitations: □ **None** List:

_____

Medications at School: □ **None** **(If medications are needed at school a Physician's signature is required.)**

Name	**Dose**	**Route**	**Times to be Administered**

Side effects/adverse reactions: _____

Contraindications for Administration: _____

Physician's Signature _____ **Date:** _____

Print/Stamp physician name, address and phone number:

Hemophilia Action Plan (con't)

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All medication for use at school will be furnished by parent or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

Parent Permission

I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release Neuse Charter School Board of Directors and their agents and employees from all liability that may result from my child taking the prescribed medication. This consent is good for one year, unless revoked.

I give permission to designated staff members of Neuse Charter School to perform and carry out the tasks as outlined by this Hemophilia Action Plan. I also consent to the release of the information contained in this Hemophilia Action Plan to all staff members and other adults who have custodial care of my child and who need to know this information in order to maintain my child's health and safety.

Acknowledged and received by:

Parent/Guardian _____ Date _____

Parent Email address _____ Parent Phone Numbers _____

EMERGENCY CONTACTS: Name/Relation

1._____a) home_____ b) work _____ c) cell_____

2._____a) home_____ b) work _____ c) cell_____

3._____a) home_____ b) work _____ c) cell_____

Principal's Signature _____ Date _____

School First Responder Signature _____ Date _____