HORTONVILLE AREA SCHOOL DISTRICT

BLEEDING DISORDER ACTION PLAN

Student Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Phone Number/Cell: _____

Parent/Guardian Name: _____ Phone Number/Cell: _____

Other Emergency Contact: _____ Relation: _____ Phone: _____

Treating Physician: _____ Phone: _____ Fax: _____

Significant Medical History: _____

Type of Bleeding Disorder:

Hemophilia A

Mild *Moderate* *Severe*

Hemophilia B

Mild *Moderate* *Severe*

Von Willebrand

Type 1 *Type 2* *Type 3*

Factor II **Factor V** **Factor VII**

Factor X **Factor XII**

Other: _____

Indications for Staff Intervention:

- Painful, swollen joints
- Swelling in the leg or arm (especially knee or elbow when bleeding)
- Inability to move body part
- Bruises with raised, tender, enlarged areas
- Excessive bleeding from minor cuts
- Spontaneous nose bleeds, uncontrolled by first aide
- Blood in urine
- Head or throat injury
- Severe blow to the body
- Report by student that there is a bleed
- Indicators specific to the student: _____

Emergency Bleeding Disorder Medications:

Medication	Dose (mg, mcg)	Route	When to use

MEDICATION CONSENT: I hereby give permission to designated trained school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the practitioner as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I further agree to hold the Hortonville Area School District, and the HASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any change in the above orders is necessary. If self-medication is allowed, I ask that my child be permitted to self-medicate as authorized by my physician and myself. I understand, as the parent, I am responsible to assure that backup rescue medication is available to my child after school hours and traveling to/from and during school-sponsored events.

Activity limitations/restrictions: _____

First Aide:

1. Control the bleed by applying pressure to the site for 10-15 minutes. Keep limb elevated and DO NOT REMOVE PRESSURE
2. Administer ordered medications, if available
3. Notify Parents
4. Allow child to rest
5. Notify nurse

Call 911 if student has the following:

- Bleeding is uncontrolled
- Bleeding is in head or neck region (except nosebleeds)
- Severe pain
- Slow or rapid breathing
- Severe swelling of joints or injury site
- Weak or rapid pulse
- Shock: pale/cool skin, blue/grey color to skin, lips or ears

Nurse Signature: _____ **Date:** _____

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

Physician Signature: _____ **Date:** _____