Hemophilia
Emergency Action Plan

Student: DOB:	Parent/Guardian:
Today's Date:	Home Phone/Cell:
Teacher: Grade: Car#	Work Phone:

Healthcare Provider *please complete the information requested below:*

1. Type of Hemophilia: _____.
2. Severity of Hemophilia:

_____ MILD (Clotting factor 5-50% of normal. Usually only has problems after major injuries).

_____ MODERATE (Clotting factor 1% to 5% or normal. Occasional bleeding episodes after injuries.)

_____ SEVERE (Clotting factor less than 1% of normal. May have bleeding without apparent cause or with only slight injury.)

3. Usual bleeding pattern (include last date and details of bleeding episode):

_____

_____

4. Measures used to control bleeding: _____Pressure _____Ice_____ Elevation

Other (specify):_____

5. Does this student require replacement factor? _____ Yes _____ No

(Please complete the enclosed medication form if replacement factor is part of the plan of care for this student while at school.)

6. Has this student required hospitalization for hemophilia? _____ Yes ____ No

If yes, when: _____

Healthcare Provider Signature: _____Date:_____

Address_____ _____

Phone_____

Nurse Signature: _____ Date: _____