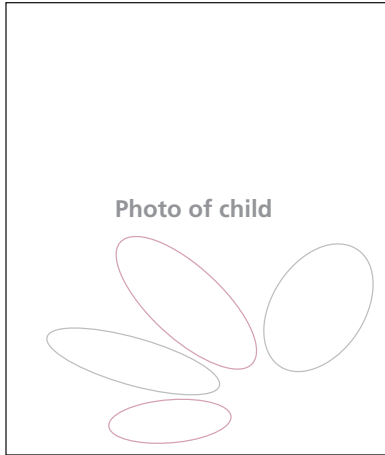


# ITP STUDENT FACTSHEET



Child's full name \_\_\_\_\_



Child's age \_\_\_\_\_

Child's birthday \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Allergies \_\_\_\_\_

Medications \_\_\_\_\_

\_\_\_\_\_ *Child's name* has a platelet disorder called immune thrombocytopenia purpura (ITP). This causes a condition of low platelets and means he/she has trouble properly clotting his/her blood when injured and may bruise and bleed more easily.

**In case of accident, head injury, or emergency bleeding (mouth, nose, cut, vomit, etc.), please contact:**

First Parent / Caregiver Name (Printed) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

eMail \_\_\_\_\_

Second Parent / Caregiver Name (Printed) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

eMail \_\_\_\_\_

**This child's doctor is:**

Doctor's Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

**Additional Information / Comments**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

