Little Cypress-Mauriceville CISD

Cardiac Condition Action Plan

School Year: _____

Student: _____ DOB: _____ Grade _____

Parent/Guardian: _____ Phone: _____ Alt. Phone: _____

Physician Name: _____ Phone: _____

Known Allergies: _____

Dear Parent/Guardian:
School records indicate your child has a cardiac condition. In order to attend to your child's health and safety, the school requires a complete medical history. Please return this form to the nurse as soon as possible. It will become part of your child's confidential school health record. With your written consent, this information will be shared with specific school personnel strictly on a "need to know" basis. Please keep us informed of any changes in your child's condition or medication schedule. Our primary concern is that your child's health needs are met while in school or during school activities.

What type of cardiac condition does your child have? **(Please check √ all that apply)**

☐ Aortic Stenosis ☐ Coarctation of the aorta ☐ Congestive heart failure ☐ Hypertension
☐ Murmur ☐ Rheumatic heart disease ☐ Septal Defect ☐ Tetralogy of fallot
☐ Patent ductus arteriosis ☐ Transposition of the great arteries
☐ Surgery Type _____ When? _____
☐ Other (specify) _____

Your child's signs and symptoms of a cardiac episode are? **(Please check √ all that apply)**

☐ Chest tightness or pain ☐ Shortness of breath or difficulty breathing
☐ Tires easily ☐ Irritability ☐ Blue or gray color around mouth, lips or fingernails
☐ Change in activity tolerance ☐ Paleness of skin ☐ Fainting or dizziness
☐ Other (specify) _____

How often does your child have symptoms? _____
When was the last time? _____

Has your child ever been hospitalized? ☐ Yes ☐ No If yes, when? _____

*Please list the medications your child takes for his/her **cardiac condition** :*

Name of Medication	Dosage	Time	Side Effect

*Does your child take any **other** medications?*

Name of Medication	Dosage	Time	Side Effect

Does you child have any activity or dietary restrictions? ☐ Yes ☐ No
Doctor's letter is required if activity is limited (be specific) _____

Parent/Guardian Signature: _____ Date: _____

Student Name: _____ Little Cypress-Mauriceville CISD

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If medications must be given during school hours, an Authorization for Medication form must be completed every school year. It must be filled out and signed by you and your physician. Medications used in school must be in the original container and properly labeled. When you have a prescription filled, ask the pharmacist for two containers; one for school and one for home use.

CONSENT

Please circle your response and sign: (I do / I do not) give the School Nurse my permission to share information relevant to my child's medical status with school staff on a "need to know" basis, if she/he determines that this information is necessary to assure my child's health and safety.

Parent/Guardian Signature: _____ Date _____

Follow the attached Physician Action Plan; if no plan submitted, call 911 and parent/guardian.

School Responsibilities/ Agreements	Family Responsibilities/ Agreements	Student Responsibilities/ Agreements
Medication Kept: Staff authorized to administer medication (Review plan, recognize symptoms, and respond)	*Provide medication for school site and replace any expired or used medication.*	*Report early warning signs of cardiac distress.*
Trained staff to administer medications per Authorization for Medication:	Keep school staff informed of any changes in student condition or medications	
Staff to contact 911/parent/guardian:	Parent or designated adult as noted as emergency contact to respond to school when called.	
Activate School Emergency Response Team: *CPR/& AED certified staff on campus:*		
Special Instructions for substitute teachers/ staff:		Inform substitute that you are cardiac patient if having any of the early warning signs of distress.

Baseline Vital Signs: Blood pressure: _____ Heart Rate: _____ Respirations: _____

O2 Saturation: _____ Temperature: _____ Date _____

_____ _____ _____

Physician Signature Phone Number Date

Nurse Evaluation Initial Assessment (sign & date) _____

PRN Update (sign & date)

Parental/Guardian Approval of student Cardiac Condition Action Plan:

_____ _____ _____

Parent/Guardian Signature Phone Number Date