# Cardiac Care Plan for School

*- - - Plan must be renewed each school year - - -*

Student's Name: _____ Date of birth: _____ Grade: _____

Teacher:_____

## TO BE COMPLETED BY PHYSICIAN

| **Current Diagnoses** | **History/Past Diagnoses/Surgeries** |
|---|---|
| | |

*Does this student have any internal or external IV lines, ports, or Cardiac Devices? ☐ **No** ☐ **Yes**
If yes, please list and explain:

**Activity/PE restrictions:** If yes, please list and explain: ☐ **No** ☐ **Yes**

| **MEDICATIONS** (home AND school) | Name of Medicine | Dose | Frequency/Time | Give at School |
|---|---|---|---|---|
| ***EMERGENCY*** Medication(s) | | | | |
| | | | | |
| *ROUTINE Medication*(s) | | | | |
| | | | | |
| | | | | |

☐ YES
☐ NO

It is my professional opinion that this student should be allowed to carry and self-administer emergency medications listed above while on school property or at school-related events. I have instructed the student in the proper way to use the medication. The student is both capable and responsible for self-administering and caring for the medication.

**Cardiac Emergency Plan:** Since the student is at risk, however slight, of having a sudden cardiac arrest, it is essential that. an emergency plan be in place.

| | |
|---|---|
| ☐ *If the student should faint*, lay the student flat and obtain vital signs and monitor student for regaining consciousness. (Unless parent specifies different directions) | ☐ Other: If other please list: |
| ☐ *If the student is unconscious but is breathing and has a pulse/heart rate,* call 911, monitor student and obtain vital signs for EMS. | ☐ Other: If other please list: |
| ☐ *If the student is unconscious with no pulse/heart rate and no breathing* call 911, begin CPR, Obtain AED, continue CPR until help arrives or AED announces rhythm is restored, obtain vital signs for EMS. | ☐ Other: If other please list: |
| ☐ *If the student is experiencing symptoms* of palpitations, feeling of rapid heart rate, and/or chest pain but has normal vital signs, is alert and oriented, the parent should be notified and advised to seek medical care. | ☐ Other: If other please list: |

Physician's Name (print): _____ Phone: _____

Physician's Signature: _____ Date: _____

Address: _____ City/Zip: _____

Student's Name: _____ Student ID: _____

## TO BE COMPLETED BY PARENT/GUARDIAN

Describe your child's usual symptoms of cardiac condition.

Are there any factors that trigger cardiac complications in your child?

Besides medications, do you do anything else that helps?

| Emergency Contact/Relationship | Phone | Emergency Contact/Relationship | Phone |
|---|---|---|---|
| | | | |
| | | | |

*I have reviewed this School Care Plan and request that it be implemented for my child. I will notify the school nurse immediately if there is any change in my child's health status, medical providers, emergency contact information, or any of these treatments and/or procedures. Information concerning my child's health condition may be shared with and/or obtained from school personnel and my child's healthcare providers as appropriate and needed.*

*Signature of Parent/Guardian* _____ *Date*_____

## TO BE COMPLETED BY SCHOOL NURSE

***EMERGENCY*** medication(s) will be kept:

☐ With student
- physician signature required (see above)
- verify student's technique and understanding of treatment.
- label medication as "approved" to carry

☐ In school health clinic
☐ _____

★ ***EMERGENCY*** medication(s) must accompany student at school-sponsored events off school grounds. ★

**Directions for Emergency Medications**

Staff members trained to assist student if school nurse is absent:

| Name/Location/Assignment | Date Trained | Name/Location/Assignment | Date Trained |
|---|---|---|---|
| | | | |
| | | | |

*School Care Plan reviewed by:*

*Signature of School Nurse* _____ *Date*_____