

CARDIAC INDIVIDUAL HEALTH PLAN

(Parent/guardian to complete this form)

STUDENT NAME _____ DOB _____ SCHOOL _____

GRADE _____ TEACHER _____ SCHOOL YEAR _____

PARENT/GUARDIAN _____ BEST CONTACT/PHONE NUMBER _____

PHYSICIAN _____ PHONE _____

CARDIOLOGIST _____ PHONE _____

What is the name of your child's cardiac condition?

Please describe your child's cardiac condition.

Has your child ever had a surgery or surgeries for this condition? Yes No If yes, please describe:

Does your child take a medication at home every day for this condition? Yes No If yes, what medication?

Does your child have a doctor's order for medication for this condition to be given at school, and is the medication at school? Yes No

Does your child have a pacemaker? Yes No

Has your child needed emergency room treatment for this condition within the past year? Yes No
If yes, please describe.

In the event that you cannot be reached, please list the name(s) and phone number(s) of persons who are familiar with your child's condition and have knowledge of how to manage this condition. *Please also add this person(s) to your child's pick-up list in case they may need to pick your child up from school due to their condition.*

Name: _____

Phone Number: _____

Name: _____

Phone Number: _____

Is there anything else you would like school staff to know about your child's condition?

PLEASE NOTE: We recommend talking with your child's doctor to see if they recommend an Emergency Action Plan. Please review the back of this form for steps school staff may take in the event of a medical emergency. These will be followed if your child does not have an Emergency Action Plan at school for this condition.

- I give permission for my child, _____, to receive care for the medical condition listed above by designated school staff.
- School nurse may share information regarding this condition with my child's doctor.

PARENT/GUARDIAN SIGNATURE _____

DATE _____

SCHOOL NURSE SIGNATURE _____

DATE _____

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STUDENT NAME _____

Note: If student also has an Emergency Action Plan (EAP) for this condition, please refer to the EAP for actions school staff should take instead. Otherwise, follow the steps below.

This student has an EAP: Yes No

Symptoms:

- | | |
|---|--|
| <input type="checkbox"/> Racing heart rate | <input type="checkbox"/> Chest pain or discomfort |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Excessive shortness of breath |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Unusual fatigue |
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Other: _____ |

Interventions:

1. Stay with student; student should not leave location or be left alone.
2. Allow student to rest and encourage fluids.
3. Call 911 if unable to arouse. Notify front office to direct EMS to student's location.
4. Call or radio for help if needed. Designated first responder school staff should respond to the student's location, and bring any needed emergency equipment, such as an AED.
5. Notify parents/guardians, or designate another staff member to notify:
Parent/guardian name: _____ Phone number: _____
Emergency contact name: _____ Phone number: _____
6. Notify school nurse, if in building. If school nurse is not present, notify upon return or via other communication.

Additional information:
