**Cardiac Individual Health Care Plan**

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Year: \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_

Cardiac Disorder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiac Procedures/Operations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximate dates – attach additional page if needed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: Yes No If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Asthmatic: Yes No

Baseline: Pulse \_\_\_\_\_\_\_\_\_ B/P \_\_\_\_\_\_\_\_\_\_\_ 02 Saturations \_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_

My child may experience the following symptoms (please check all that apply)

* “Feels like heart is beating too fast”
* Short of breath
* Changes in color around mouth, lips or nail beds
* Dizziness
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following may indicate a worsening of this child’s cardiac disease (please check all that apply)

* Decreased level of consciousness
* Clammy, cool skin
* Dizziness
* Shortness of breath
* A marked change of color: pale or blue
* Chest pain
* Other – Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student has the following other health conditions/disabilities:

Student limitations or special considerations:

**Emergency Contacts:**

Parents/Guardians

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Other Emergency Contact if parent/guardian is unavailable:*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tel #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The steps that should be taken for a cardiac event are:

1. Check for pulse, respirations, 02 Saturation, and level of consciousness
2. Call 911 if:
3. Pulse is lower than \_\_\_\_\_\_\_ or higher than \_\_\_\_\_\_\_
4. Respirations are lower than \_\_\_\_\_\_\_ or higher than \_\_\_\_\_\_\_
5. 02 Saturation is lower than \_\_\_\_\_\_\_
6. Unconscious or unresponsive
7. Have student lie down with feet elevated

If there is a decreased level of consciousness or absent pulse or respirations:

1. Call 911 or delegate someone else to call 911
2. Begin CPR and obtain AED if available
3. Have someone contact Parent/Guardian
4. Have someone obtain students medical and personal information to transport along with student

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following recommendations are based on the student’s cardiovascular status. These recommendations should be considered in the context of other medical considerations that are part of the general medical evaluation. Our recommendations are as follows (please check):

* No restrictions (includes interscholastic athletics and contact sports)
* Moderate exercise (includes physical education classes and recreational sports but should avoid activities which require maximum or sustained effort)
* Light exercise (includes non-strenuous recreational games such as swimming, jogging or golf)
* Must be permitted to determine his/her own level of activity and stop to rest as needed
* No physical education classes

All Current Medications

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Dose | Purpose | Schedule |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

By signing below, parent/guardian gives permission to transport \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to the nearest emergency medical facility with a designated person accompanying child, taking a signed emergency card. Parent(s)/guardian will assume all responsibility financially and otherwise, if necessary. Parent/guardian authorizes the school nurse to communicate with the physician listed below regarding this medical condition.

**Reviewed by:**

|  |  |  |  |
| --- | --- | --- | --- |
| Parent/Guardian Printed Name | Parent/Guardian Signature | Date | |
| Physician Printed Name | Physician Signature | Date | NPI # |
| School Nurse Printed Name | School Nurse Signature | Date | |