Carroll County Public Schools
Parent Health Questionnaire – Cardiac

Student Name: ___________________________________ Date: _______

Date of Birth: _______________ Grade: ______

You have indicated on the Emergency Procedure Card and/or health forms that your child has a cardiac condition or history of a cardiac condition. Please complete the following questionnaire and return to your school nurse as soon as possible.

1. What is the name of the heart condition?

   ____

2. How old was your child when the diagnosis was made? _______________________________________

3. Do you consider this condition to be life threatening? Yes ___ No ___

4. Has your child been hospitalized or had heart surgery related to the heart condition?
   Yes____ No____
   Date(s) of Hospitalization:____
   Date(s) of Surgery: ____

5. How often/when does your child experience a problem as a result of the heart condition?

   ____

   ____

6. What is your child's normal blood pressure: ___/___ Pulse: ____ Respiratory Rate: ____

7. List current medications:

Medication	Dose	How often used:	Side Effects

8. Will any medications be needed at school? If so, which medications?

   ____

9. Does your child require antibiotics for dental work? Yes ____ No ____
   Deep Cuts? Yes ____ No ____ Minor Surgery? Yes ____ No ____

10. Describe symptoms experienced by child as a result of the heart condition (circle all that apply):

Fainting	Cyanosis	Chest pain	Confusion
Trouble breathing	Palpitations	Irregular heart	Pale
Dizziness	Chronic fatigue	Sweating with cool skin	

Irregular heart rhythm or pulse
Heart rate (pulse) over _____ bpm or under _____ bpm. Other: ______________

11. Please describe any actions that may assist your child with this problem while in school:
____
____

12. Please list any restrictions or limitations:
____
____

13. Does your child understand the heart condition and what he/she should do to manage it? Please describe:
____
____

14. If a student is unable to participate in the physical education program for a period in excess of three consecutive days, a physician's statement is required. The physician should state the nature of the disability/illness and the length of time the student's activity is restricted (please request PE modification form as needed).

15. Name and phone number of Health Care Provider managing treatment of cardiac condition:
Health Care Provider name: ______________________________
Phone Number: _______________________

Please note: Medication will only be given following CCPS Medication Procedures. The information you supply will be handled in a confidential manner to be used by the school nurse to guide care if an emergency arises. If clarification is required beyond this form, the nurse will contact the parent/guardian and/or the child's health care provider. If you have questions, please call the school nurse.

_____________________________ ______________
Parent/Guardian Signature Date

Received by School Nurse:
_____________________________ ______________
Nurse Signature Review Date