Post Falls School District #273
School Nursing Services
206 W. Mullan Ave, Post Falls ID 83854
PO Box 40, Post Falls, ID 83877
(208) 773-6976

Cardiac Information

Dear Parent/Guardian:

If your child has a cardiac condition please complete this form and return it to your child's school.

Student's Name: _____
School: _____ Grade: _____ Teacher: _____
Parent/Guardian: _____Phone: _____
Physician's Name: _____ Phone: _____

1. What is your child's cardiac diagnosis/condition/concern? _____
_____
2. When did cardiac condition begin? _____
3. Has your child had cardiac surgery? ☐ No ☐ Yes: _____
4. Has your child been medically cleared? ☐ No ☐ Yes: _____
5. Does student have any restrictions? ☐ No ☐ Yes: _____
6. Does your child take medication for this condition? ☐ Yes ☐ No ☐ Not currently

Please list all medications prescribed, supplements or over the counter:

Medications	**Dose/Time**	**Side Effects:**

If your child needs medication at school, please bring the medication to the school office in the original container (an extra prescription bottle may be prepared for school at the pharmacy).

*An **Authorization for Medication Administration** form will need to be completed.*

7. If the school nurse has more questions regarding this form what is your preferred method of contact?
☐Phone or ☐ Email: _____

Parent/Guardian's signature: _____ Date: _____

Thank you,
Elizabeth Costin, BSN, RN
Post Falls School District Lead Nurse

Revised: June 2020