



Carroll ISD Health Services
Parental Authorization- Cardiac/ CV Action Plan

Parent please answer:	
Special Ed services?	yes / no
Active 504 plan?	yes / no
I would like 504 information	yes / no

Name: _____ **D.O.B.:** _____ **Grade/Teacher:** _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Transportation: Car rider Walker Drives self Rides bus # _____

Before/After school activities: Athletics Band Club: _____ Tutoring Other _____

Diagnosis/Significant medical history: _____

Allergies: _____

Current **Medications** to treat cardiac condition: _____

Keep in Clinic? yes no

Date of last hospitalization: _____

Treatments/ Procedures/ Devices:

Oxygen: _____

Other: _____

Specific Activity limitations or Restrictions: Yes/ No (explain):

PE/ Outdoor Activity/ recess: _____

Athletics/ Extra-Curricular: _____

Other: _____

Does Student Need:

Medication at school? yes no

Vital Signs Monitoring? yes no

Environmental Mgmt/ safety assistance? yes no

Fluid Management Assistance? yes no

Nutrition Management Assistance? yes no

Infection Protection Instruction? yes no

If you answered yes to any of the above, please provide detail, i.e. vital signs parameters:

Standard Cardiac/CV Emergency Plan for School- Please review and make changes/ additions as needed.

<p>Minor Symptoms If You See Any of These:</p> <ul style="list-style-type: none"> • Verbalizes "Feels like heart is beating too fast" • Shortness of Breath • Changes in Color around mouth or lips or nail beds • Dizziness • Other signs/ symptoms 	<p>Do This:</p> <ul style="list-style-type: none"> • Stop activity • **Student may need rescue/ prescribed medication • Call the Nurse/ Office for assistance: check pulse, respirations saturation, and level of consciousness • Place student in comfortable position • Stay with the Student- DO NOT LEAVE ALONE
<p>Severe Symptoms If You See Any of These:</p> <ul style="list-style-type: none"> • Decreased level of consciousness • A marked change in color: pale or blue • Chest pain • Absent pulse or respirations <p>SIGNS/ SYMPTOMS ABOVE MAY INDICATE BLEEDING AND SHOULD NOT BE TAKEN LIGHTLY.</p>	<p>Do This:</p> <ul style="list-style-type: none"> • Call or have someone CALL 911 • Call the Nurse/ Office for assistance • Start CPR if indicated <p><u>CONTACT PARENT AS SOON AS POSSIBLE</u></p>
<p>Additional Instructions:</p> <p>_____ _____</p>	

I grant permission to Carroll ISD to follow the above plan for my child. I am giving permission to CISD to contact my physician for additional information as necessary. If the school nurse deems necessary, I grant permission to notify my student's teacher of his/ her health plan.

Physician- Print Name:	Physician Phone:
Parent/ Guardian Signature:	Parent/ Guardian Phone: