Cherokee County School District

CARDIAC ACTION PLAN

This Action Plan is to be completed and signed by the child's parent/guardian and physician. The information on this plan is confidential. All staff involved in the care for your child will have access to this information in order to provide the optimal safety in the school setting. Please contact the school at any time if you need to update this Action Plan.

Student Name_____ DOB _____ Grade____

Parent/Guardian_____ Phone Number_____

Parent/Guardian_____ Phone Number_____

Emergency Phone Contact # 1_____ Phone Number_____

Emergency Phone Contact # 2_____ Phone Number_____

Physician Treating Student for Cardiac Issues_____

Phone Number of Physician_____

Other Physicians_____

_____

_____

Cardiac Diagnosis

Please describe this student's Cardiac Diagnosis/Disability:

_____

_____

_____

_____

- Cardiac Warning Signs_____

  _____

- Cardiac Symptoms_____

  _____

- Last Cardiac Event_____

- Cardiac Surgeries_____

Special Equipment / Activity Restrictions

- Does this student have any special internal or external equipment we need to consider in the school setting?

  □ No

  □ Yes - Please describe_____
  (Parent will provide supplies/equipment)

- Is student allowed to participate in physical education or other activities at school?

  □ No - Please explain/list limitations_____

  _____

  □ Yes - may fully participate

Prevention Measures

Please list any environmental control measures or dietary restrictions the student requires to aid in preventing a cardiac episode:

_____

_____

Medications

Daily Medication	Dosage, Route, and Time of Day Given	Side Effects/Special Instructions

Emergency Response

A "cardiac emergency" for this student is defined as:

_____

_____

_____

Cardiac Emergency Protocol

Check all that apply:

□ Call 911

□ Activate School Emergency Response Plan – CPR/AED

□ Contact School Nurse

□ Notify Parent or Emergency Contact

□ Administer emergency medications as indicated below

□ Other_____

Emergency Medications

Emergency Medication	Dosage & Route	Side Effects/Special Instructions

Other Instructions:

_____

_____

_____

I give permission for school personnel to release a copy of this Emergency Response Plan to emergency personnel in the event it is necessary to activate Emergency Medical Services and/or transport my child to the hospital.

I, _____, herby authorize the named healthcare provider who has attended to my child to furnish to the School/Health Services or School Clinic staff any medical information and/or copies of records pertaining to my child's chronic health condition, and for this information to be shared with pertinent school staff. This authorization expires as of the last day of this school year.

Parent's Signature_____ Date_____

Physician's Signature_____ Date_____