COLUMBIA FALLS SCHOOL DISTRICT

CARDIAC ACTION PLAN

SY____________

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 that cares for your child will have access to this information in order to provide 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 Name______________________________________ Ph: (h)__________________

Address____________________________ Ph: (w)________________ Ph: (c)________________

Emergency Phone Contact #1____

Name Relationship Phone #

Emergency Phone Contact #2____

Name Relationship Phone #

Physician Treating Student for Cardiac issues____

Name Phone #

Other Physician____

Name Phone #

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

  No ☐ - Please explain/list limitations____

  ____

  Yes ☐ - May fully participate

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CARDIAC ACTION PLAN

(Continued)

Student Name________________________________ **DOB**________________

Prevention Measures – please list any **environmental control measures** or **dietary restrictions** the student requires to aid in preventing an asthma episode ____

Medications

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

Emergency Response

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

Cardiac Emergency Protocal – (Check all that apply and clarify below)

- ☐ **Call 911**
- ☐ Contact school nurse at ____________________
- ☐ 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 the 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.

Reviewed/Revised on ________________ Parent Signature ________________________

Reviewed/Revised on ________________ **Physician Signature** ________________________

Reviewed/Revised on School Nurse Signature

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CARDIAC ACTION PLAN

(Continued)

Student Name____DOB________________

Please sign below if there are no changes to the Cardiac Action Plan, for the current school year. If there are changes please complete a new cardiac action plan.

School Year__________-__________Grade__________

Date Reviewed_________________Physician Signature______________________________

Date Reviewed_________________Parent/Guardian Signature________________________

Date Reviewed_________________School Nurse Signature___________________________

School Year__________-__________Grade__________

Date Reviewed_________________Physician Signature______________________________

Date Reviewed_________________Parent/Guardian Signature________________________

Date Reviewed_________________School Nurse Signature___________________________

School Year__________-__________Grade__________

Date Reviewed_________________Physician Signature______________________________

Date Reviewed_________________Parent/Guardian Signature________________________

Date Reviewed_________________School Nurse Signature___________________________

School Year__________-__________Grade__________

Date Reviewed_________________Physician Signature______________________________

Date Reviewed_________________Parent/Guardian Signature________________________

Date Reviewed_________________School Nurse Signature___________________________