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

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 | Fluid Management Assistance? ◯ yes ◯ no

Vital Signs Monitoring? ◯ yes ◯ no | Nutrition Management Assistance? ◯ yes ◯ no

Environmental Mgmt/ safety 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:

____

____

<table>
<tr><th colspan="2">Standard Cardiac/CV Emergency Plan for School- Please review and make changes/ additions as needed.</th></tr>
<tr><td>Minor Symptoms
If You See Any of These:
• Verbalizes “Feels like heart is beating too fast”
• Shortness of Breath
• Changes in Color around moth or lips or nail beds
• Dizziness
• Other signs/ symptoms</td><td>Do This:
• 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</td></tr>
<tr><td>Severe Symptoms
If You See Any of These:
• Decreased level of consciousness
• A marked change in color: pale or blue
• Chest pain
• Absent pulse or respirations
SIGNS/ SYMPTOMS ABOVE MAY INDICATE BLEEDING AND SHOULD NO BE TAKEN LIGHTLY.</td><td>Do This:
• Call or have someone CALL 911
• Call the Nurse/ Office for assistance
• Start CPR if indicated
<u>CONTACT PARENT AS SOON AS POSSIBLE</u></td></tr>
<tr><td colspan="2">Additional Instructions:</td></tr>
</table>

I grant permission to Cleburne 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:

Revised 6/05/2023