



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 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 _____ School Year _____

Parent/Guardian Name _____ Ph: (H) _____ Ph: (W) _____ Ph: (c) _____

Parent/Guardian Name _____ Ph: (H) _____ Ph: (W) _____ Ph: (c) _____

Emergency Contact Name: _____ Relationship: _____ Ph: _____

Emergency Contact Name: _____ Relationship: _____ Ph: _____

Physician's Name: _____ Address: _____ Ph: _____

Physician's Name: _____ Address: _____ Ph: _____

Cardiac Diagnosis- please describe this student's Cardiac Diagnosis/Disability/Surgeries

<p>Emergency Response A "cardiac emergency" for this student is defined as: _____</p> <p>Cardiac Emergency Protocol—(check all that apply and clarify below)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Call 911 <input type="checkbox"/> Initiate CPR _____ <input type="checkbox"/> Utilize AED <input type="checkbox"/> Notify parent or emergency contact <input type="checkbox"/> Administer emergency medications as indicated below <input type="checkbox"/> Oxygen Saturation level _____ <input type="checkbox"/> Other _____ 	<p>Emergency Medications</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Name</th> <th style="text-align: left;">Dosage & Route</th> <th style="text-align: left;">Time</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table> <p>Other Instructions: _____ _____</p> <p>Oxygen saturations Ranges for student _____</p> <p>Comments: _____ _____</p>	Name	Dosage & Route	Time	_____	_____	_____	_____	_____	_____
Name	Dosage & Route	Time								
_____	_____	_____								
_____	_____	_____								
<p>Special Equipment: Does student have any special internal or external equipment we need to consider in the school setting?</p> <ul style="list-style-type: none"> <input type="checkbox"/> No <input type="checkbox"/> Yes –please describe _____ <p>Magnetic Restrictions: Does student have any restrictions related to magnetic devices, electronic devices, and microwave?</p> <ul style="list-style-type: none"> <input type="checkbox"/> No <input type="checkbox"/> Yes –please describe specific limitations related to devices listed above _____ <p>Daily Medications/Treatments</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Name</th> <th style="text-align: left;">Dosage, Route</th> <th style="text-align: left;">Time</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table> <p>Prevention Measures– please list any environmental control measures or dietary restrictions student requires to aid in prevention: _____</p>	Name	Dosage, Route	Time	_____	_____	_____	_____	_____	_____	<p>Activity Restrictions: <input type="checkbox"/> Refrain from ALL Physical Education (PE) activities. <input type="checkbox"/> No excuse indicated: Student should participate in PE <input type="checkbox"/> Student may participate on a limited basis as indicated below. <input type="checkbox"/> Student will require special protective equipment to participate in physical education :Specify equipment _____</p> <p>Limitation of the following physical activities: <input type="checkbox"/> Contact sports <input type="checkbox"/> Aerobics <input type="checkbox"/> Running <input type="checkbox"/> Gymnastics <input type="checkbox"/> Low impact sports <input type="checkbox"/> Floor exercises <input type="checkbox"/> Walking <input type="checkbox"/> Other (please explain) _____</p> <p>Physician's Signature: _____ Date _____</p> <p>Parent's Signature: _____ Date _____</p>
Name	Dosage, Route	Time								
_____	_____	_____								
_____	_____	_____								



Parent /Guardian Authorization for School Staff to Communicate Health Information

I authorize the District’s designees, including District medical professionals to share/obtain my student’s health related information with the medical health professional or health care provider identified above to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, and medical treatments.

Parent/ Guardian initials _____

I give permission to my child’s school to administer daily and emergency medications as necessary, in accordance with physician’s instructions above.

Parent/Guardian’s Signature

Date

Autorización del padre de familia/tutor para que el Personal Escolar Comuniquen los Datos Médicos

Autorizo a los representantes del Distrito, incluyendo los profesionales médicos del Distrito, a competir y obtener los datos médicos de mi hijo/a para planificar, implementar o aclarar las acciones necesarias en la administración de servicios escolares relacionados con la salud, que incluyen pero no se limitan a: atención de urgencia, cuidado para cualquier diagnóstico, o tratamientos médicos con el profesional médico o proveedor de salud identificado anteriormente.

Iniciales del Padre/tutor _____

Doy mi permiso para que la escuela de mi hijo/a le dé el/los medicamento(s) necesario diariamente o de emergencia de acuerdo con las instrucciones del médico indicado en la primera parte de esta forma.

Firma de Padre/Tutor

Fecha