MEDICAL REPORT on CARDIAC STUDENT

DATE (given)_____

NAME_____ D.O.B._____

ADDRESS_____ SCHOOL_____

INITIAL REFERRAL_____ ANNUAL FOLLOW-UP_____

I. As a result of this examination of this child, the following diagnosis has been made:
   1. **HEART DISEASE**---------- YES---------- NO
   2. **Rheumatic heart disease**---------- YES---------- NO
   3. **Congenital heart disease**---------- YES---------- NO
   4. **Classification functional capacity:** Class I Class II Class III Class IV
      Therapeutic classification: Class A Class B Class C Class D Class E
      (***See reverse side for description of classification of patients with heart disease***)
   5. Annual evaluation---------- YES---------- NO
   6. Further comments_____

II. **History and laboratory data:** This child had the following signs and symptoms:
   Pain in joints, limbs Palpitations Abdominal pain Loss of appetite
   Sore throat-frequent cold Fatigue Twitching Pallor Nosebleeds Irritability
   Month_____ Day_____ YEAR_____
   Laboratory date for tests: Echocardiography Cardiac Catheterization Surgery
   Chest X-Rays Angiography Electrocardiogram Other_____

ACTIVITY PROGRAM RESTRICTIONS Start date_____ End date_____

Please provide what accommodations, if any are needed, by checking the activities below the student may/not participate in this year.

		YES	NO
Warm-Up exercise:	Stretching, walking		
Low Impact Aerobic:	Jumping, hopping, jogging, dance, TaeBo		
Stunts:	Tumbling, rolling, balance, strength		
Physical Fitness Testing:	Running, sit-ups, push-ups, pull-ups		
Non-Contact Games:	Paddle ball, jump rope, badminton, tennis, bowling, other racket sports		
Weight Training Program:	Free weights, treadmill		
Track And Field:	Sprints, intermediate & distance running, long jump, high jump, shot-put		
Apparatus:	Climbing, vaulting, support, suspension		
Competitive Games:	Soccer, hockey, basketball, baseball, softball, wiffle-ball, volleyball, speedball, touch football		
Recess Play:			

Stair climbing (circle): **YES** **NO** ***Number of flights of stairs allowed per day**_____

Use of helmet in gym: **YES** **NO** in recess: **YES** **NO** in class: **YES** **NO**

OTHER PROTECTIVE and/or **ASSISTIVE DEVICES** (please specify):_____

OTHER RESTRICTIONS:_____

PHYSICIAN PRINT / STAMP_____ **PHONE**_____

PHYSICIAN SIGNATURE_____ **DATE**_____

_____ INITIAL EXAM _____ ANNUAL FOLLOW UP

Approved by School Physician_____ **Date**_____

CLASSIFICATION OF PATIENTS WITH DISEASE OF THE HEART

FUNCTIONAL CAPACITY:

Class I Patients with cardiac disease but **WITHOUT RESULTING IN LIMITATIONS OF PHYSICAL ACTIVITY**, Ordinarily physical activity does not cause undue fatigue, palpitations, dyspnea or anginal pain.

Class II Patients with cardiac disease resulting in: **SLIGHT LIMITATIONS OF PHYSICAL ACTIVITY**. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea or anginal pain.

Class III Patients with cardiac disease resulting in: **MARKED LIMITAITON OF PHYSICAL ACTIVITY**. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea or anginal pain.

Class IV Patients with a cardiac disease resulting in: **THE INABILITY TO CARRY OUT ANY PHYSICAL ACTIVITY WITHOUT DISCOMFORT.** Symptoms of cardiac insufficiency or of the anginal syndrome are present even at rest. If any physical activity is undertaken discomfort is increased.

THERAPEUTIC CLASSIFICATIONS:

Class A Patients with a cardiac disease whose **ordinary physical activity need not be restricted.**

Class B Patients with a cardiac disease whose **ordinary physical activity need not be restricted,** but who **should be advised against severe or competitive physical efforts.**

Class C Patients with cardiac disease whose **ordinary physical activity should be moderately restricted,** and whose **more strenuous efforts should be discontinued.**

Class D Patients with cardiac disease whose **ordinary physical activity should be markedly restricted.**

Class E Patients with cardiac disease who **should be at complete rest, confined to bed or a chair.**

*UNDIAGNOSED MANIFESTATION

Patients with symptoms or signs referable to the heart but in whom a diagnosis of cardiac disease is uncertain should be classified tentatively as **UNDIAGNOSED MANIFIS-TATION.**
Re-examination after a suitable interval will usually help to establish a definite diagnosis. When there is a reasonable probability that the signs or symptoms are not of cardiac origin, the title **UNDIAGNOSED MANIFESTATION** should not be used. The diagnosis then should be **NO HEART DISEASE.**

*NO HEART DISEASE: PREDISPOSING ETIOLOGICAL FACTORS

These are patients in whom no cardiac disease is discovered, but whose course should be followed by periodic examinations because of the presence or history of an etiological factor that might cause heart disease. These cases should be recorded as **NO HEART DISEASE: PREDISPOSING ETIOLOGICAL FACTOR** and it is essential that the etiological diagnosis also be stated.

***For some patients both diagnoses will apply.**

SCHOOL # _____ SCHOOL YEAR _____

PATERSON PUBLIC SCHOOLS

AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS TO BE GIVEN DURING REGULAR SCHOOL HOURS

Date Given _____ Date Returned _____ Medication Started (1st dose) _____

Student's Name _____ DOB ____/____/____ Grade _____

PHYSICIAN: (medications to be given during regular school hours)

Please give the above named student the following;

Medication: _____

Dosage: _____

Time: _____

Purpose: _____

Diagnosis: _____

Medication to be taken during regular school hours:

Printed Name of Physician: _____ Address: _____

Physician's Signature: _____ Telephone: _____

Fax #: _____

****

PARENT:

I hereby give my permission for the above prescription to be given to: _____
(Print Student Name)

Parent/Guardian Signature _____ **Date** _____

APPROVED:

I hereby approve the above request for medication to be given during regular school hours.

School Doctor / Administrator _____ Date _____

****

All medications must be brought to the school by a responsible adult in the original container, appropriately labeled by the pharmacy. All medications must be counted by the school nurse, in the presence of the parent/guardian, and signed for.

All medications will be kept in a locked cabinet in the School Health Office, and administered by the School Nurse at the appropriate time.

School Nurse _____ ☎ 973-321-_____

SCHOOL # _____ SCHOOL YEAR _____

PATERSON PUBLIC SCHOOLS

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS FOR ASTHMA OR OTHER POTENTIALLY LIFE THREATENING ILLNESS

STUDENT'S NAME _____ DATE _____ GRADE _____

The above student is to take the following medication during school hours:

Medication: _____ Dosage: _____

Frequency: _____ Route: _____

Purpose: _____ Diagnosis: _____

1. It is my opinion that the medication can be self-administered during school hours by this student in school and on field trips. Instruction regarding proper care and administration procedure has been given to him/her and the parent /guardian. (A-2600) N.J.S.A. 18A:40-12.3

Family Physician's Name _____ Telephone _____

Physician's Signature _____ Date _____

****

2. I, _____ (print parent / guardian name) the parent/guardian of _____ (print student's name), give my permission for this medication to be self-administered during school hours. I am aware that the Paterson School District shall not incur any liability as a result of this self-administration, and I hold the district harmless in ANY injury or claims that arise as a result of my child's possession and/or self-administration of this medication.

Parent/Guardian's signature _____ Telephone _____

Address _____ Date _____

****

I HEREBY APPROVE THE ABOVE REQUEST FOR SELF-ADMINISTRATION OF THIS MEDICATION DURING SCHOOL HOURS.

_____ _____

SCHOOL PHYSICIAN'S SIGNATURE DATE

All medication must be brought to the school nurse by a responsible adult, in the original container appropriately labeled by the pharmacy.

NOTE: THIS LETTER WILL BE KEPT ON FILE IN THE NURSE'S OFFICE FOR THE REMAINDER OF THIS SCHOOL YEAR. PERMISSION FOR THE SELF-ADMINISTRATION OF MEDICATION MUST BE RENEWED ANNUALLY.

School Nurse _____ Date _____

SCHOOL # _____ SCHOOL YEAR _____

PATERSON PUBLIC SCHOOLS

AUTHORIZATION FOR THE ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS TO BE GIVEN DURING REGULAR SCHOOL HOURS

Date Given _____ Date Returned _____ Medication Started (1st dose) _____

Student's Name _____ DOB ____/____/____ Grade _____

PHYSICIAN: (medications to be given during regular school hours)

Please give the above named student the following;

Medication: _____

Dosage: _____

Time: _____

Purpose: _____

Diagnosis: _____

Medication to be taken during regular school hours:

Printed Name of Physician: _____ Address: _____

Physician's Signature: _____ Telephone: _____

Fax #: _____

****

PARENT:

I hereby give my permission for the above prescription to be given to: _____
(Print Student Name)

Parent/Guardian Signature _____ **Date** _____

APPROVED:

I hereby approve the above request for medication to be given during regular school hours.

School Doctor / Administrator _____ Date _____

****

All medications must be brought to the school by a responsible adult in the original container, appropriately labeled by the pharmacy. All medications must be counted by the school nurse, in the presence of the parent/guardian, and signed for.

All medications will be kept in a locked cabinet in the School Health Office, and administered by the School Nurse at the appropriate time.

School Nurse _____ ☎ 973-321-

SCHOOL # _____ SCHOOL YEAR _____

PATERSON PUBLIC SCHOOLS

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS FOR ASTHMA OR OTHER POTENTIALLY LIFE THREATENING ILLNESS

STUDENT'S NAME _____ DATE _____ GRADE _____

The above student is to take the following medication during school hours:

Medication: _____ Dosage: _____

Frequency: _____ Route: _____

Purpose: _____ Diagnosis: _____

1. It is my opinion that the medication can be self-administered during school hours by this student in school and on field trips. Instruction regarding proper care and administration procedure has been given to him/her and the parent /guardian. (A-2600) N.J.S.A. 18A:40-12.3

Family Physician's Name _____ Telephone _____

Physician's Signature _____ Date _____

****

2. I, _____ (print parent / guardian name) the parent/guardian of _____ (print student's name), give my permission for this medication to be self-administered during school hours. I am aware that the Paterson School District shall not incur any liability as a result of this self-administration, and I hold the district harmless in ANY injury or claims that arise as a result of my child's possession and/or self-administration of this medication.

Parent/Guardian's signature _____ Telephone _____

Address _____ Date _____

****

I HEREBY APPROVE THE ABOVE REQUEST FOR SELF-ADMINISTRATION OF THIS MEDICATION DURING SCHOOL HOURS.

_____ _____

SCHOOL PHYSICIAN'S SIGNATURE **DATE**

All medication must be brought to the school nurse by a responsible adult, in the original container appropriately labeled by the pharmacy.

NOTE: THIS LETTER WILL BE KEPT ON FILE IN THE NURSE'S OFFICE FOR THE REMAINDER OF THIS SCHOOL YEAR. PERMISSION FOR THE SELF-ADMINISTRATION OF MEDICATION MUST BE RENEWED ANNUALLY.

School Nurse _____ Date _____

HEALTH OFFICE

School #24/Fine and Performing Arts Program

Grade_____ Home #_____

Student's Name_____

Mother's Name_____

Father's Name_____

Address_____

City_____

Home Phone #_____

Mother's Cell #_____

Father's Cell #_____

Parent Signature _____

EMERGENCY CONTACT NUMBERS TO FOLLOW:

1. Name_____

   Relation_____

   Emergency # _____

2. Name_____

   Relation_____

   Emergency # _____

3. Name_____

   Relation_____

   Emergency # _____

PATERSON PUBLIC SCHOOL DISTRICT
90 DELAWARE AVENUE
PATERSON, NEW JERSEY 07503

NURSING SERVICES

DATE _____

Name and Address of Hospital or Health Care Provider:

_____

_____

_____

To Whom it May Concern:

This is to certify that I, _____, the parent / legal guardian of _____, do hereby give my written consent for you to release any medical records that you might have in your possession concerning _____ (Date of Birth) _____.

(Parent /Guardian Name)

(Student Name)

(Student Name)

Please send records; attention school nurse: _____

School Name and Address: ⇨ _____

_____

_____

School Nurse Signature: _____ Telephone No: (973) 321-__ __ __ __

_____

Signature of Parent or Guardian

PATERSON PUBLIC SCHOOLS DISTRICT
90 DELAWARE AVENUE
PATERSON, NEW JERSEY 07503

DEPARTMENT OF NURSING SERVICES

Date:_____

Name and Address of School Nurse and Public School:

_____

_____

_____

To Whom It May Concern:

This is to certify that I,_____ the

Parent/Legal Guardian of _____ Grade_____, do

hereby give my written consent for you to release or obtain any medical records that you might have in your possession concerning_____ DOB_____

Please send records to the attention of the Hospital or Health Care Provider at:

Health Care Provider Address →_____

_____

_____

Signature of
Parent or Guardian:_____

Signature of
Health Care Provider:_____Telephone #:_____

Signature of
School Nurse:_____Telephone #:_____

PATERSON PUBLIC SCHOOLS DISTRICT
90 DELAWARE AVENUE
PATERSON, NEW JERSEY 07503

DEPARTMENT OF NURSING SERVICES

Parent/Guardian Permission to Release and Exchange Confidential Health Information

Student Name: _____ **DOB:** _____

Address: _____ **Student ID#**_____

To Whom It May Concern:

This is to certify that I,_____, the parent/legal guardian of _____, hereby authorize an exchange of information regarding my child, _____, to occur between the school and staff members who interact with_____.

This information may also be shared with the Intervention and Referral Service Team, Child Study Team, and /or the 504 Team if needed.

This authorization is in effect for the School Year: _____

Parent/Guardian Name (Print): _____
Parent/Guardiain Signature: _____ **Date:** _____
School Nurse: _____ Telephone Number: _____