Heart Health Condition

Date:_________

*Please fill out this form and turn it in to your student's secretary. A new form must be completed every school year!

Student Name:____ DOB:_____________________________

School:____ Teacher:___________________________

What Heart Health Condition does your student have? (Please check which apply.)
Atrial septal defect (ASD): ☐ Atrioventricular canal defect: ☐ Bicuspid aortic valve: ☐ Coarctation of the aorta: ☐ Congenital mitral valve anomalies: ☐ Hypoplastic left heart syndrome: ☐ Kawasaki disease: ☐ Long QT syndrome: ☐ Patent ductus arteriosus (PDA): ☐ Patent foramen ovale: ☐ Pulmonary valve stenosis: ☐ Tetralogy of Fallot: ☐ Ventricular septal defect (VSD): ☐ Wolff-Parkinson-White (WPW) syndrome: ☐ Other:_____________________ ☐
Is your student currently taking any medications for this Heart Health Condition? (Please list medication below if applicable.) Yes: ☐ No: ☐
Does your student require specific care in the event of an Emergency? (Please list below and attach a Care Plan from student's doctor.) Yes: ☐ No: ☐
Does your student have any limitations/things staff need to be mindful of? (Please explain below.) Yes: ☐ No: ☐
Does your student have any Emergency Medications? (Please list below.) Yes: ☐ No: ☐
Where is the Emergency Medication located? (Please check which apply.) Home: ☐ Office: ☐ Student Locker: ☐ With Student: ☐
Is there a Care Plan from the doctor on file for your student for this year? Yes: ☐ No: ☐

Additional Comments: ____
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Parent/Guardian Name (printed): ____

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Signature:____