

LIBERTY SCHOOL DISTRICT #362

History for a Student with Cardiac Condition at School

Student's Name: _____ Date: _____

Parent/Guardian Name _____ Phone: _____

Physician Advising Care of Cardiac Condition _____
Phone: _____

1. What is the name of the cardiac condition?
2. How long has your child had this condition?
3. What tests, procedures, and/or surgery has your child needed for this condition?
4. What happens to your child when there is a problem with this condition?
5. What medications does your child take for this condition daily? Does your child need to take medication at school?
6. What medication or treatment does your doctor recommend when there is a problem with this condition?
7. What kinds of symptoms would your child have at school that you would consider an emergency? What do you want the school to do in an emergency?
8. Are there activities or circumstances that will likely cause a problem with this condition?
9. Are there restrictions on activities at school? Can your child participate in all school activities?

ADDITIONAL COMMENTS:

Signature of Parent/Guardian _____ Date: _____