

Student Name: _____ **DOB:** _____
 School: _____ Year: _____
 Grade: _____ Student #: _____
 Teacher: _____
 Transportation: Walker Bus Parent/Guardian Student Driver Other: _____

EMERGENCY CARE PLAN

CARDIAC SYMPTOMS

IMMEDIATE RESPONSE

Possible New or Worsening Symptoms:

- Pain in the chest, front or back
- Rapid or irregular heart rate
- Shortness of breath, difficulty breathing, or noisy breathing
- Dizziness/lightheadedness
- Sweating
- Skin color changes
- Irritability, fear, or panic
- Unusual fatigue
- Fainting

Some students may not be able to communicate their symptoms clearly because of their age or developmental challenges.

Follow student specific orders for when to administer medications & call 911. Each student's needs are unique to their diagnosis.

1. Keep student in their current location, maintain adult supervision
2. If medication* at school, follow provider instructions for administration and document time medication was administered
3. Call 911 and request AED to student location if symptoms worsen or are not improving
4. Contact School Nurse and parent/guardian

If the student is unresponsive, not breathing, and/or has no pulse, start CPR, turn on AED and follow prompts.

Student Specific Emergency Response

Cardiac Diagnosis/Symptoms:

Diagnosis: _____ **Date of Diagnosis:** _____

Implanted Cardiac Device: No Yes, describe: _____

Symptoms Present Most Days: None Fatigue Fluid retention Shortness of breath

Abnormal vitals, describe: _____

Skin color change, describe: _____

Other: _____

Activity/Restrictions:

Contraindications/Restrictions (epinephrine, grapefruit, magnets, electronic devices): No Yes, list: _____

Physical Activity Guidelines: No restrictions Yes restrictions, describe: _____

Relevant History (frequency of cardiology visits/date of last visit, transplant, surgery, congenital vs. acquired):

Medications/Interventions:Allergies: No Yes If yes, list: _____Medication at School: No Yes If yes, list: _____*Location of Medication at School: Health Room Self-Carry Location: _____ Other: _____Medication at Home: No Yes If yes, list: _____

Preferred Hospital: _____

Supplementary Information:

Before signing, parent/guardian should review and complete this IHP in its entirety. A new IHP must be submitted each school year. The School Nurse must be notified if any changes are needed to this plan during the school year.

- LWSD schools do not staff a nurse on site during all school hours.
- Teacher will communicate medical concerns to their substitutes by placing a copy of each health plan in the substitute file.
- School Nurse will ensure a copy of the health plan is kept in the health room, available for field trips, and in Skyward for staff.
- According to Washington State Law (RCW 28A.210.320), the attendance of every child shall be conditioned upon the presentation before or on the child's first day of attendance, a medication or treatment order addressing any life-threatening health condition that the child has that may require medical services to be performed at school. Once such an order has been presented, the child shall be allowed to attend school.
- Regarding Disaster Planning in Schools: In the event of a major disaster, such as a severe earthquake, the school may be responsible for the care of students for up to 72 consecutive hours. It is recommended that parents provide the school with a 72-hour supply of medications taken daily at home, if applicable.

Parents / Guardians:

Name	Relationship	Phone Number	Second Phone	Address
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Additional Contact (optional):

Parent Name (Print): _____

Parent Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____