



Emergency Action Plan for Cardiopulmonary Conditions

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 if this plan needs to be updated.

Student Name: _____ DOB: _____ Grade: _____

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Cardiologist's Name: _____ Phone: _____

Cardiac Diagnosis – Please describe this student's Cardiac Diagnosis/Disability/Surgeries:

<p>Emergency Response A "cardiac emergency" for this student is defined as:</p> <hr/> <hr/> <p>Cardiac Emergency Protocol (check all that apply and clarify below)</p> <p>☐ Call 911</p> <p>☐ Initiate CPR</p> <p>☐ Utilize AED</p> <p>☐ Notify parent or emergency contact</p> <p>☐ Administer emergency medication as ordered</p> <p>☐ Oxygen saturation level:</p> <hr/> <p>☐ Other</p> <hr/>	<p>Daily Medications/Treatments</p> <table border="0"> <tr> <th>Name</th> <th>Dosage</th> <th>Time</th> </tr> <tr><td>_____</td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td></tr> </table> <p>Emergency Medication</p> <table border="0"> <tr> <th>Name</th> <th>Dosage</th> <th>Time</th> </tr> <tr><td>_____</td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td></tr> <tr><td>_____</td><td></td><td></td></tr> </table> <p>Normal Oxygen Saturation level for student:</p> <hr/>	Name	Dosage	Time	_____			_____			_____			Name	Dosage	Time	_____			_____			_____		
Name	Dosage	Time																							

Name	Dosage	Time																							

<p>Special equipment (does the student have any internal or external equipment that needs to be considered in the school setting?)</p> <p>☐ Yes</p> <p>☐ If yes, describe</p> <hr/>	<p>Activity Restrictions</p> <p>☐ None; student is able to participate in all physical activity/exercise</p> <p>☐ Refrain from ALL physical activity/exercise</p> <p>☐ Student may participate on a limited basis as indicated:</p>																								



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<p>☐ No</p> <p>Magnetic Restrictions (does the student have any restrictions related to magnetic devices, electronic devices, and/or microwave?)</p> <p>☐ Yes</p> <p>☐ If yes, describe</p> <p>_____</p> <p>☐ No</p>	<p>_____</p> <p>☐ Student requires special protective equipment in order to participate in physical activity/exercise:</p> <p>_____</p> <p>☐ Other:</p> <p>_____</p> <p>_____</p>
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Parent/Guardian Signature: _____ Date: _____

Physician Name: _____ Physician Contact Information: _____

Physician Signature _____ Date: _____

Parent/Guardian Authorization for School Staff to Communicate Health Information

_____(please initial) 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.

_____(please initial) I give permission to my child's school to administer daily and emergency medications as necessary in accordance with the physician's instructions above.