GWINNETT COUNTY PUBLIC SCHOOLS
HEALTH AND SOCIAL SERVICES

CARDIOVASCULAR
Health Management Plan
SCHOOL YEAR: _____

STUDENT NAME:	**DOB:**
SCHOOL:	**STUDENT ID:**

Parent/Guardian	**Parent/Guardian**
Phone:	**Phone:**
Phone:	**Phone:**
Emergency Contact:	
Name:	**Phone:**
Physician:	**Phone:**
Hospital Preference:	

CARDIAC DIAGNOSIS: _____ **DATE OF LAST CARDIOLOGY APPT:** _____
Student History:

SURGICAL HISTORY:

MEDICATIONS (name, dose, frequency):

MANAGEMENT:
Activity: _____
Diet: _____
OTHER: _____
_____

CALL PARENT/GUARDIAN IF:
_____
_____

CALL 911 and HAVE SOMEONE GET THE AED IF STUDENT: (DO NOT LEAVE THE STUDENT)
- Collapses/faints
- Has a change in level of consciousness
- Experiences shortness of breath
- Is sweaty/clammy
- Other: _____

School Clinic: Copy of plan to be provided to Transportation Supervisor

_____ _____
PARENT/GUARDIAN SIGNATURE DATE CLUSTER NURSE SIGNATURE DATE

Information about students and family is strictly confidential.

Rev. 2/2024