GILBERT
PUBLIC SCHOOLS

REQUEST FOR MEDICAL DOCUMENTATION

Cardiac Care

Date: _____

Dear Parent:

Attached you will find forms for your student for the upcoming school year. The attached forms are:

1. Cardiac Emergency Care Plan
2. School Request for Physician's Orders
3. Request for School Administration of Prescription Medication (if needed).
   Please Note: The Staff in our health office is not able to obtain the Physician's signature. This will need to be completed by the parent/guardian.
4. Activity Restriction Form. If student does have restrictions, the form is to be filled out by the health care provider.
5. Bus Plan to be filled out by the parent. (Optional)

All completed paperwork and supplies, if any, must be brought to the school prior to your student's first day. The Health Office cannot accept medication until the Physician forms are completed and returned. If so desired, health staff will schedule a meeting to discuss your student's health condition.

Feel free to contact your school health office with any questions or concerns.

Thank you.

Student Name: _____

School Nurse/Health Assistant _____

School Name: _____

Phone Number: _____ Fax _____

Cardiac Care Plan

STUDENT NAME: _____ **DOB:** _____

School: _____ School Year _____ Grade _____

Homeroom Teacher _____ ☐504 ☐IEP

Student ID#: _____ Walker ☐ Bus Rider ☐ Bus Number _____

Parent/Guardian: _____

Address: _____

Guardian 1: Cell Phone: _____ Work Phone: _____

Guardian 2: Cell Phone: _____ Work Phone: _____

Physician: _____ Phone: _____

Preferred Hospital: _____ Allergies: _____

CARDIAC CONDITION:
Other pertinent information:
EMERGENCY ASSESSMENT / PLAN
If found unconscious / unresponsive **INITIATE CPR** Use Automated External Defibrillator (AED if possible) CALL 9-1-1

If you see the following:	**What to do:**
Dizziness / feeling faint	• Have student lie down and elevate legs • Attempt to check heart rate • If symptoms persist (still dizzy lying, cannot sit up) **CALL 9-1-1** • If symptoms improve (no longer dizzy when sitting up) offer fluids and call parents
Palpitations (rapid / irregular heart beat	• Use calming approach • Reassure student • Attempt to check heart rate • If symptoms persist (palpitations continue despite above) **CALL 9-1-1** • If symptoms improve, call parents
Chest Pain	• Use calming approach • Have student lie down • If severe and having dizziness or shortness of breath associated with chest pain, **CALL 9-1-1** • If moderate and persists longer than 10 minutes, **CALL 9-1-1** • Notify parents
Bleeding / severe bruising (for student on anticoagulant therapy)	• Notify parents immediately • If student experiences injury to head / abdomen, complaints of back / belly pain, or coughing / urinating / vomiting blood: **CALL 9-1-1** • For minor cuts / light bleeding, provide basic first aid

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Cardiac Care Plan

STUDENT NAME: _____ **DOB:** _____

School: _____ **Year:** _____ **Grade:** _____

Homeroom Teacher: _____

Abnormal Heart Rhythms

____ Atrial Flutter
____ Atrial Tachycardia
____ Long QT Syndrome (LQTS)
____ Supraventricular Tachycardia
____ Ventricular Tachycardia (VT)
____ Wolff- Parkinson- White Syndrome (WPW)
____ Other: _____

Acquired Heart Conditions

____ Cardiac Transplant
____ Cardiomyopathy
____ Congestive Heart Failure
____ Endocarditis
____ Kawasaki's
____ Rheumatic Heart Disease

Cardiac Devices

____ ASD/ VSD Occlusion Device
____ Implantable Cardiac Defibrillator (ICD)
____ Pacemaker
____ Prosthetic Heart Valve (Aortic, Mitral)
____ PDA Occlusion Device
____ Other: _____

Congenital Heart Defects

____ Aortic stenosis
____ Atrial Septal Defect (ASD)
____ Atrioventricular Septal Defect (AVSD/ AV canal)
____ Coarctation or the Aorta
____ Double Inlet Left Ventricle
____ Double Outlet Right Ventricle
____ Ebstein's Malformation
____ Hypoplastic Left Heart Syndrome (HLHS)
____ Mitral Stenosis/ Insufficiency
____ Patent Ductus Arteriosus (PDA)
____ Pulmonary Atresia
____ Pulmonic Stenosis/ Insufficiency
____ Tetralogy of Fallot (TOF)
____ Total/ Partial Anomalous Pulmonary Venous Return (TAPVR/ PAP)
____ Transposition of the Great Arteries (TGA)
____ Tricuspid Atresia
____ Truncus Arteriosus
____ Ventricular Septal Defect (VSD)

Cardiac Care Plan

STUDENT NAME: _____ **DOB:** _____

School: _____ School Year _____ Grade _____

Homeroom Teacher _____

Date	Surgical/ Interventional Procedures

Daily Medications:

Cardiac Medications	Dose	Frequency	Common Side Effects

Lock Down (72 hour supply) - in case of Lock Down please administer:

Cardiac Medications	Dose	Time	Common Side Effects

Out to parent for completion:_____ RN initials:_____	

Cardiac Care Plan

Signature Page

STUDENT NAME: _____ **DOB:** _____

School: _____ School Year _____ Grade _____

Homeroom Teacher _____

_____ _____

Licensed Healthcare Professional Signature Licensed Healthcare Professional Print Name

Care Plan start date: _____

Care Plan end date (not to exceed current school year): ☐ Last day of school _____
☐ Other: _____

LHP Phone # _____ LHP Fax # _____

PARENT:

- I have reviewed the information on this School Cardiac Care Plan and Medication Orders and request/authorize trained school employees to provide this care and administer the medications in accordance with the Licensed Healthcare Provider's (LHP's) instructions.
- The plan must be updated each year and when there are major changes to the plan (such as change in medication type or dose).
- All medication supplied must come in its originally provided container with instructions as noted on page 3 by the licensed health care provider.
- I authorize the exchange of medical information about my child's cardiac condition between the LHP office and school nurse.

The provider's office is encouraged to fax or email the completed plan to the student's school nurse.

School Nurse fax: _____

School Nurse Email: _____@gilbertschools.net

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

GILBERT
PUBLIC SCHOOLS

School Request for Physician's Orders

Date: _____

Dear Dr. _____,

We would like to request that you complete the attached form, Physician's Orders for Administration of Specialized Heath Care Procedures, for:

Student's name: _____

who attends: _____
(Name of School)

This form will give authorization to school personnel to perform or assist with your patient's special procedure(s).

A standardized procedure for _____ has been attached for your review. Please make whatever changes are necessary to meet the individual needs of your patient or send your own protocol. School personnel will not be permitted to perform such services until these forms are completed and received.

Thank you for your cooperation in this matter. This will assist us in maximizing this student's participation in our school program. Please call if you have any concerns or questions.

Sincerely,

_____ _____
School Personnel/Title Phone Number

Gilbert Public Schools
Health Services Department

REQUEST FOR SCHOOL ADMINISTRATION OF PRESCRIPTION MEDICATION

In order for children to receive medicine while at school, the following form (both parts A and B) must be completely filled out and returned to the school prior to its administration.

School Year _____ - _____

A. Parent's Request for giving Medication at School (To be filled out by parent/legal guardian)

I request that the designated staff member give my child, _____
Student's Name

the medication prescribed by our health care provider _____
Name of Provider

The medication is to be furnished by me and is to be in the original container from the pharmacy with the label matching the written doctor's order. If any changes in medication or dosage occur, the school must be notified immediately and a new form must be completed. Student's misuse of medication being self-administered will result in confiscation and disciplinary action. I authorize the physician to speak with the Registered Nurse regarding my child and this medication.

I DO ☐ I DO NOT ☐ consent to transmission of my child's medical records electronically.

_____ _____
Signature of Parent / Guardian Date

_____ _____ _____
Work Phone Home Phone E-Mail address or Fax #

B. Health Care Provider's Order for Medication at School (To be filled out by Provider)

I request the following student be given medication at school because I believe there exists a valid health reason which makes the administration of medication advisable during the time a student is under supervision of school officials.

_____ _____
Student's Name Birthdate

_____ _____
Condition being treated Medication to be administered

_____ _____
Dosage and mode of administration Time to be given at school

_____
Inclusive dates during which medication is to be given

_____
Side effects to be expected. What emergency measures should be taken if this occurs?

_____
Other medications being taken at home or at school

_____ _____
Health Care Provider's Name (Print) Health Care Provider's Signature

_____ _____
Address Date

_____ _____
Health Care Provider's Phone # Health Care Provider's Fax #

Activity Restriction Form

This form may be filled out by parents/guardians if there are NO restrictions. Form is to be signed by healthcare provider if there are restrictions.

Name: _____ Date of Birth: _____

Diagnosis: _____

Restrictions from Physical Education and/or recess in the excess of 5 days require a health care provider's written documentation.

☐ May participate in P.E./sports/recess without restrictions.

☐ May NOT participate in P.E./sports/recess until: _____.

☐ May participate in P.E./sports/recess with the following restrictions (please check all that apply):

- ☐ No running
- ☐ No jumping
- ☐ No swimming
- ☐ No climbing
- ☐ No lifting greater than _____ pounds.

☐ Outdoor activity only when the outside temperature is below _____ degrees.

☐ List any other restrictions not mentioned above:

_____

Print Name of Health Care Provider

_____

Health Care Providers Signature Date

_____

Phone Number

I give consent for the exchange of information regarding my student's activity restrictions.

_____

Parent/Guardian Signature Date

LAM/May 2019

Transportation Individual Healthcare Plan - Cardiac

Student Picture

_____/_____ _____ _____--_____
AM PM Bus Route # School Year

Stop Location: _____

Name of Student: _____

Student ID Number: _____ **Age / Grade:** _____

School/Program: _____ **Teacher:** _____

Student Condition: **Cardiac Condition**

If found unconscious/unresponsive, INITIATE CPR, USE AED if available, **CALL 911**

If you see the following	What to do
• Dizziness/feeling faint • Palpitations (rapid / irregular heartbeat) • Chest pain	**Pull bus over safely.** **Call 911** **Call bus barn**

Emergency Contact Names: _____ _____

Phone Numbers: Home # _____ Home# _____

Cell# _____ Cell # _____

I give permission for this information/document to be shared with any bus driver and monitor on the bus.

Parent Signature: _____ Date: _____

Nurse Signature: _____ Date: _____ Phone : _____

Transportation Office: Shred this document at the end of the school year