Andrews Independent School District

CARDIAC ACTION PLAN

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 at any time if you need to update this Action Plan.

Student Name_____ DOB_____ Grade_____ School Year_____
Parent/Guardian Name_____ Ph: (H) _____ Ph: (W) _____ Ph: (c) _____
Parent/Guardian Name_____ Ph: (H) _____ Ph: (W) _____ Ph: (c) _____
Emergency Contact Name: _____ Relationship: _____ Ph: _____
Emergency Contact Name: _____ Relationship: _____ Ph: _____
Physician's Name: _____ Address: _____ Ph: _____
Physician's Name: _____ Address: _____ Ph: _____

Cardiac Diagnosis- please describe this student's Cardiac Diagnosis/Disability/Surgeries

_____
_____
_____

Emergency Response
A "cardiac emergency" for this student is defined as:

_____
_____

Cardiac Emergency Protocol–(check all that apply and clarify below)
o Call 911
o Initiate CPR _____
o Utilize AED
o Notify parent or emergency contact
o Administer emergency medications as indicated below
o Oxygen Saturation level _____
o Other _____
_____

Emergency Medications
Name Dosage & Route Time

_____
_____
_____

Other Instructions:

_____
_____
_____

Oxygen saturations
Ranges for student_____

Comments:_____
_____

Special Equipment: Does student have any special internal or external equipment we need to consider in the school setting?
o No
o Yes –please describe _____
_____

Magnetic Restrictions: Does student have any restrictions related to magnetic devices, electronic devices, and microwave?
o No
o Yes –please describe specific limitations related to devices listed above

_____
_____

Daily Medications/Treatments
Name Dosage, Route Time

_____
_____
_____

Prevention Measures– please list any environmental control measures or dietary restrictions student requires to aid in prevention:

_____

Activity Restrictions:
___Refrain from **ALL** Physical Education (PE) activities.
___No excuse indicated: Student should participate in PE
___Student may participate on a limited basis as indicated below.
___Student will require special protective equipment to participate in physical education :Specify equipment

_____

Limitation of the following physical activities:
___Contact sports ___Aerobics ___Running ___Gymnastics
___Low impact sports ___Floor exercises ___Walking
___Other (please explain)

_____
_____

Physician's Signature:

_____Date_____

Parent's Signature:

_____Date_____