



Carroll County Public Schools Parent Health Questionnaire – Cardiac

Student Name: _____

Date: _____

Date of Birth: _____

Grade: _____

You have indicated on the Emergency Procedure Card and/or health forms that your child has a cardiac condition or history of a cardiac condition. Please complete the following questionnaire and return to your school nurse as soon as possible.

1. What is the name of the heart condition?

2. How old was your child when the diagnosis was made? _____

3. Do you consider this condition to be life threatening? Yes ____ No ____

4. Has your child been hospitalized or had heart surgery related to the heart condition?

Yes ____ No ____

Date(s) of Hospitalization: _____

Date(s) of Surgery: _____

5. How often/when does your child experience a problem as a result of the heart condition?

6. What is your child's normal blood pressure: ____/____ Pulse: ____ Respiratory Rate: ____

7. List current medications:

Medication	Dose	How often used:	Side Effects

8. Will any medications be needed at school? If so, which medications?

9. Does your child require antibiotics for dental work? Yes ____ No ____

Deep Cuts? Yes ____ No ____

Minor Surgery? Yes ____ No ____

10. Describe symptoms experienced by child as a result of the heart condition (circle all that apply):

Fainting	Cyanosis	Chest pain	Confusion
Trouble breathing	Palpitations	Irregular heart	Pale
Dizziness	Chronic fatigue	Sweating with cool skin	
Irregular heart rhythm or pulse			
Heart rate (pulse) over _____ bpm or under _____ bpm. Other: _____			

11. Please describe any actions that may assist your child with this problem while in school:

12. Please list any restrictions or limitations:

13. Does your child understand the heart condition and what he/she should do to manage it? Please describe:

14. If a student is unable to participate in the physical education program for a period in excess of three consecutive days, a physician's statement is required. The physician should state the nature of the disability/illness and the length of time the student's activity is restricted (please request PE modification form as needed).

15. Name and phone number of Health Care Provider managing treatment of cardiac condition:

Health Care Provider name: _____

Phone Number: _____

Please note: Medication will only be given following CCPS Medication Procedures. The information you supply will be handled in a confidential manner to be used by the school nurse to guide care if an emergency arises. If clarification is required beyond this form, the nurse will contact the parent/guardian and/or the child's health care provider. If you have questions, please call the school nurse.

Parent/Guardian Signature

Date

Received by School Nurse:

Nurse Signature

Review Date