

Student with Cardiac Condition at School – Short History

Student's Name: _____ Date: _____

Parent/Guardian Name: _____ Phone: _____

Physician Advising Care of Cardiac Condition: _____

Physician's Phone: _____

1. What is the name of the cardiac condition? _____
2. How long has your child had this condition? _____
3. What tests, procedures, surgery has your child needed for this condition: _____

4. What happens to your child when there is a problem with this condition? _____

5. What medications does your child take for this condition daily? _____
Does your child need to take medication at school? _____
6. What medication or treatment does your doctor recommend when there is a problem with this condition? _____

7. What kind of symptoms would your child have at school that you would consider an emergency?
What do you want the school to do in a emergency? _____

8. Are there activities or circumstances that will likely cause a problem with this condition? _____

9. Are there restrictions on activities at school? Can your child participate in all school activities? _____

10. Is there any new information that you want to tell the school regarding your child's condition? _____

11. How do you want the school to treat a seizure if it should occur at school? _____

12. Comments: _____

Signature or Parent/Guardian: _____ Date: _____