

Fayette County School Health Services

CARDIAC HEALTH CARE PLAN

Please bring or mail this health care plan to the school or send to the secure FAX at 770-719-2639.

Student: _____ Birth Date: _____ School Year: _____

School: _____ Homeroom Teacher: _____ Grade/Team: _____

EMERGENCY CONTACTS:

<i>Parent/Guardian/Contact</i>	<i>Relationship</i>	<i>Phone Number</i>	<i>Email</i>

<i>Primary Healthcare Provider:</i>	<i>Phone Number:</i>
<i>Cardiologist:</i>	<i>Phone Number:</i>

Cardiac Disorder: _____

Cardiac Procedures/Operations: _____

Allergies Yes No If yes, describe: _____ Asthmatic? Yes No

Baseline: Pulse _____ B/P _____ O2 Saturations _____ Other _____

My Child may experience the following symptoms (please check)

"Feels like heart is beating too fast"

Short of Breath

Changes in Color around mouth or lips or nail beds

Dizziness

The following may indicate a worsening of this child's cardiac disease (please check)

Decreased level of consciousness

Clammy, cool skin

Dizziness

Shortness of breath

A marked change in color: pale or blue

Chest pain

Other – Describe: _____

MEDICATIONS (including daily and emergency medications):

<i>Medication Name</i>	<i>Dosage (amount)/Time</i>	<i>When To Use</i>	<i>Given at School</i>
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO

► **IMPORTANT - PLEASE COMPLETE REVERSE SIDE AND SIGN** ◀

Student: _____ Birth Date: _____ Date: _____

SPECIAL CONSIDERATIONS AND PRECAUTIONS (including school activities, sports, and trips):

The following recommendations are based on the student’s cardiovascular status. These recommendations should be considered in the context of other medical considerations that are part of the general medical evaluation. Our recommendations are as follows (please check):

- No restrictions (includes interscholastic athletics and contact sports)
- Moderate exercise: Includes physical education classes and recreational sports but should avoid activities, which require maximum or sustained effort
- Light Exercise: includes non-strenuous recreational games such as swimming, jogging, or golf.
- Must be permitted to determine his/her own level of activity and stop to rest as needed
- No physical education classes
- Other: _____

CARDIAC EMERGENCY

The steps that should be taken for a cardiac event are:

1. Check for pulse, respirations, O2Saturation, and level of consciousness.
2. _____

If there is a decreased level of consciousness or absent pulse or respirations

1. Call 911 or delegate
2. Begin CPR and obtain AED if available
3. Contact parent/Guardian
4. Have someone obtain paperwork with personal information to go with student

► **Physician’s Signature** ◀ _____ **Date:** _____

PRINT Physician’s Name: _____ **Telephone Number:** _____

I, this child’s parent/guardian, hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Coordinator and/or School Clinic Staff any medical information and/or copies of records pertaining to my child’s chronic health condition and for this information to be shared with pertinent school staff at my child’s school. I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act (“HIPAA”) disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child’s medical needs may be served while in attendance in the Fayette County Schools. This authorization expires as of the last day of the school year.

► **Parent/Guardian’s Signature** ◀ _____ **Date:** _____

Implemented: May 2012
Revised: June 3, 2013