REED-CUSTER Cardiac Condition Action Plan

Student: ________________________ DOB: __________ School Year: ______________

School (circle one): RCPS RCIS RCMS RCHS Grade: ____ Teacher: ______________

Parent/Guardian & Phone(s): ____

Physician & Phone: ____

KNOWN ALLERGIES: ____

Dear Parent/Guardian:
School records indicate your child has a cardiac condition. In order to attend to your child's health and safety, the school requires a complete medical history. Please return this form to the nurse as soon as possible. It will become part of your child's confidential school health record. With your written consent, this information will be shared with specific school personnel strictly on a 'need to know' basis. Please keep us informed of any changes in your child's condition or medication schedule. Our primary concern is that your child's health needs are met while in school.

1. What type cardiac condition does your child have? (**check ☑ all that apply**)
   ☐Aortic stenosis ☐Coarctation of the aorta ☐Congestive heart failure ☐Hypertension ☐Patent ductus arteriosis
   ☐Murmur ☐Rheumatic heart disease ☐Septal defect ☐Tetralogy of fallot ☐Transposition of the great arteries
   ☐Surgery – Type ______________________ When? ______________
   ☐Other (specify) ______________________________

2. Your child's signs and symptoms of a cardiac episode are: (**check ☑ all that apply**)
   ☐Chest tightness or pain ☐Shortness of breath or difficulty breathing ☐Blue or gray color around mouth, lips, or fingernails
   ☐Tires easily ☐Irritability ☐Change in activity tolerance ☐Paleness of skin ☐Fainting or dizziness
   ☐Other (specify) ______________________________

3. How often does your child have symptoms? ______________________________
   When was the last time? ______________________________

4. Has your child ever been hospitalized? ☐No ☐Yes If yes, when ______________

5. Please list the medications your child takes for his/her cardiac condition:

   Name of Medication Dosage Time
   ____

6. Does your child take any **other** medications?

   Name of Medication Dosage Time
   ____

7. List any side effects your child experiences from the above medication(s)?
   ____

8. Does your child have any activity or dietary restrictions? ☐No ☐Yes ______________

9. **(Doctor's letter is required if activity is limited)**
   Be specific: ______________________________

If medications must be given during school hours, an **Authorization for Medication** form must be completed every school year. It must be filled out and signed by you and your physician. Medications used in school must be in the original container. When you have a prescription filled, ask the pharmacist for two containers; one for school and one for home use. If your student participates in field trips and needs medication during that time, a separate container may be necessary for that day as well.

CONSENT

Please circle your response and sign: (I do / I do not) give the School Nurse my permission to share information relevant to my child's medical status with school staff on a "need to know" basis, if she/he determines that this information is necessary to assure my child's health and safety.

PARENT/GUARDIAN SIGNATURE: ______________________ DATE: ______________

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Physician & Phone: ____

Follow the attached physician action plan; if no plan submitted, call 911 and parent/guardian.

School Responsibilities/Agreements	Family Responsibilities/Agreements	Student Responsibilities/Agreements
1. Medication Kept: Staff authorized to administer medication (review plan, recognize symptoms, and respond)	1. Provide medication for school site and replace any expired medication.	1. Report early warning signs of cardiac distress.
2. Trained staff to administer medications per Authorization for Medication:	2. Keep school staff informed of any changes in student condition or medications.	
3. Staff to contact 911/parent/guardian:	3. Parent or designated adult, as noted on emergency alert card, to respond to school when called.	
4. Staff to direct EMS to the emergency:		
5. CPR/& or AED certified staff:		
6. Substitute teacher instructions:		

______________________________ ______________
Parent/Guardian Signature Date

______________________________ ______________
Principal or School Administration Designee Date

______________________________ ______________
Certified School Nurse Date

Nursing Evaluations: (Sign & Date)

Initial Assessment: ____________________/_____/________

PRN Update: ____________________/_____/________

Parental approval of student Health Care Plan:

PARENT/GUARDIAN SIGNATURE: ______________________________ **DATE:** ______________