



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 involved in the care for your child will have access to this information in order to provide the 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 _____

Parent/Guardian _____ Phone Number _____

Parent/Guardian _____ Phone Number _____

Emergency Phone Contact # 1 _____ Phone Number _____

Emergency Phone Contact # 2 _____ Phone Number _____

Physician Treating Student for Cardiac Issues _____

Phone Number of Physician _____

Other Physicians _____

Cardiac Diagnosis

Please describe this student's Cardiac Diagnosis/Disability:

- Cardiac Warning Signs _____

- Cardiac Symptoms _____

- Last Cardiac Event_____
- Cardiac Surgeries_____

Special Equipment / Activity Restrictions

- Does this student have any special internal or external equipment we need to consider in the school setting?
 - No
 - Yes - Please describe_____ (Parent will provide supplies/equipment)
- Is student allowed to participate in physical education or other activities at school?
 - No - Please explain/list limitations_____
 - Yes - may fully participate

Prevention Measures

Please list any environmental control measures or dietary restrictions the student requires to aid in preventing a cardiac episode:

Medications

| Daily Medication | Dosage, Route, and Time of Day Given | Side Effects/Special Instructions |
|------------------|--------------------------------------|-----------------------------------|
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Emergency Response

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

Cardiac Emergency Protocol

Check all that apply:

- Call 911
- Activate School Emergency Response Plan – CPR/AED
- Contact School Nurse
- Notify Parent or Emergency Contact
- Administer emergency medications as indicated below
- Other _____

Emergency Medications

| Emergency Medication | Dosage & Route | Side Effects/Special Instructions |
|----------------------|----------------|-----------------------------------|
| | | |
| | | |
| | | |

Other Instructions:

I give permission for school personnel to release a copy of this Emergency Response Plan to emergency personnel in the event it is necessary to activate Emergency Medical Services and/or transport my child to the hospital.

I, _____, hereby authorize the named healthcare provider who has attended to my child to furnish to the School/Health Services 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. This authorization expires as of the last day of this school year.

Parent's Signature _____

Date _____

Physician's Signature _____

Date _____