

Cardiac Care Plan

Student Name _____ Grade _____

Parent/Guardian: _____ Hm Phone: _____
 Address: _____
 Guardian 1: Wk Phone: _____ Cell Phone: _____
 Guardian 2: Wk Phone: _____ Cell Phone: _____
 Physician: _____ Phone: _____
 Preferred Hospital: _____ Allergies: _____

HEALTH CONCERN: (Enter diagnosis here) :

Other pertinent information:

EMERGENCY ASSESSMENT/ PLAN

GOLDEN RULE: IF found unconscious/ unresponsive, initiate CPR/ use Automated External Defibrillator (AED if available), and call 911

If you see the following:	What to do:
Dizziness/ feeling faint	<ul style="list-style-type: none"> Have student lie down and elevate legs Attempt to check heart rate _____ If symptoms persist (still dizzy lying/ cannot sit up) – CALL 911 If symptoms improve (no longer dizzy when sitting up) offer fluids and call parents
Palpitations (rapid/ irregular heart beat)	<ul style="list-style-type: none"> Use calming approach Reassure student Attempt to check heart rate If symptoms persist (palpitations continue despite above) call 911 If symptoms improve call parents
Chest pain	<ul style="list-style-type: none"> Use calming approach Have patient lie down If severe and having dizziness or shortness of breath associated with chest pain, call 911 If moderate and persists longer than 10 minutes, call 911 Notify parents
Bleeding/ severe bruising (for patients on anticoagulant therapy)	<ul style="list-style-type: none"> Notify parents immediately If patient experiences injury to head/ abdomen, complaints of back/ belly pain, or coughing/ urinating/ vomiting blood: call 911 For minor cuts/ light bleeding, provide basic first aid

Parent: _____ Date: _____
 School Nurse: _____ Date: _____

Congenital Heart Defects

- Aortic stenosis
- Atrioventricular Septal Defect (AVSD/ AV canal)
- Double Inlet Left Ventricle
- Ebstein's Malformation
- Mitral Stenosis/ Insufficiency
- Pulmonary Atresia
- Tetralogy of Fallot (TOF)
- Transposition of the Great Arteries (TGA)
- Truncus Arteriosus
- Atrial Septal Defect (ASD)
- Total/ Partial Anomalous Pulmonary Venous Return (TAPVR/ PAPVR)
- Double Outlet Right Ventricle
- Hypoplastic Left Heart Syndrome (HLHS)
- Patent Ductus Arteriosus (PDA)
- Pulmonic Stenosis/ Insufficiency
- Coarctation of the Aorta
- Tricuspid Atresia
- Ventricular Septal Defect (VSD)

Acquired Heart Conditions

- Cardiomyopathy
- Endocarditis
- Rheumatic Heart Disease
- Congestive Heart Failure
- Kawasaki's
- Cardiac Transplant

Abnormal Heart Rhythms

- Atrial Tachycardia
- Long QT Syndrome (LQTS)
- Supraventricular Tachycardia
- Other: _____
- Atrial Flutter
- Wolff- Parkinson- White Syndrome (WPW)
- Ventricular Tachycardia (VT)

Cardiac Devices

- Pacemaker
- Prosthetic Heart Valve (Aortic, Mitral)
- PDA Occlusion Device
- Implantable Cardiac Defibrillator (ICD)
- ASD/ VSD Occlusion Device
- Other: _____

Date	Surgical/ Interventional Procedures

Daily Medications:

Cardiac Medications	Dose	Frequency	Common Side Effects

HCP Signature:		Print name:	
Start date:	End date: (not to exceed current school year)	<input type="checkbox"/>	Last day of school
Date:	Telephone:	<input type="checkbox"/>	Other:
		Fax:	

PARENT:

- I have reviewed the information on this School Cardiac Care Plan and Medication Orders and request/authorize trained school employees to provide this care and administer the medications in accordance with the Healthcare Provider's (HCP's) instructions.
- The plan must be updated each year and when there are major changes to the plan (such as in medication type or dose).
- All medication supplied must come in its originally provided container with instructions as noted above by the health care provider.
- I authorize the exchange of medical information about my child's cardiac condition between the HCP office and school nurse. The provider's can fax plan directly to Health Office (secure fax line) 908-647-4828

Parent/Guardian Signature

Date

RECOMMENDATIONS FOR PHYSICAL ACTIVITY

The following recommendations are guidelines for physical activity for:

___ May participate in Physical Education and Sports without restriction.

___ May not participate in Physical Education and Sports.

Duration of recommendations: _____

Additional recommendations/ accommodations:

Physician
Signature: _____
Physician
Name: _____

Phone: _____

Date _

FAX: _