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	• 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)	• 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	• 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	• 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 or 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)	☐ Last day of school ☐ Other:
Date:	Telephone:	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: _____ Date _

Physician Name: _____ Phone: _____ FAX: _

Dr. Robert J. Underwood
Superintendent

Indian Lake Schools

6210 SR 235 North
Lewistown, Ohio 43333
937-686-8601 · Fax: 937-686-8421

Coleen Reprogle
Treasurer

March 2022

Students with any medication to be stored or given at school such as daily, emergency or as needed, must provide the appropriate updated Medication Administration form **each school year**. There is a form for prescription medications that doctors sign and a different form for over the counter medications that parents simply sign when they drop off the medication for school.

Please note that Medication Administration Forms are also required for medications that students self-carry. Ohio law only lists 3 self-carry medications for school which include inhalers, epinephrine auto injector and glucagon. **ORC 3313.718** also states that in order for students to self-carry epinephrine auto injector, a second backup is to be received by the school. There is an area on the administration form for both the doctor and parent to sign consent for the student to self-carry these medications.

Remember students are not permitted to transport medications to/from school. A parent or guardian signature is necessary for medication to be signed in/out of clinic inventory. Finally, all medication **MUST** be stored in the original container with the label matching the signed doctor's order.
For questions please contact District Nurse, Kourtney Thompson at 937-686-7323.

Sincerely,

Robert J. Underwood
Superintendent

Indian Lake Elementary School
8779 CR 91
Lewistown, Ohio 43333
Phone: 937-686-7323
Fax: 937-686-0049
Molly Hall, Principal
Pamela Scarpella, Asst. Principal

Indian Lake Middle School
8920 CR 91
Lewistown, Ohio 43333
Phone: 937-686-8833
Fax: 937-686-8993
Melissa Mefford, Co-Principal, Operations
Erin Miller, Co-Principal, Instruction

Indian Lake High School
6210 SR 235 North
Lewistown, Ohio 43333
Phone: 937-686-8851
Fax: 937-686-0024
Kyle Wagner, Principal
David Coburn, Asst. Principal

Indian Lake Local Schools
Medication Administration Form
(Including Asthma Inhaler and Epinephrine Autoinjector Use)

Student Information

Student name				Date of birth
Student address				
School	Grade/Class	Teacher		School year
List any known drug allergies/reactions			Height	Weight

Prescriber Authorization

Name of medication	Circumstance for use	
Dosage	Route	Time/Interval
Date to begin medication	Date to end medication	
Circumstances for use		
Special instructions		
Treatment in the event of an adverse reaction		
Epinephrine Autoinjector ❑ Not applicable ❑ Yes, as the prescriber I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.		
Asthma Inhaler ❑ Not applicable ❑ Yes, if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or at any activity event or program sponsored by or in which the student's school is a participant.		
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief		
Possible Severe Adverse Reaction(s) per ORC 3317.716 and 3313.718 a) To the student for whom it is prescribed (that should be reported to the prescriber) b) To a student for whom it is not prescribed who receives a dose		
Other medication instructions Does medication require refrigeration? ❑ Yes ❑ No Is the medication a controlled substance? ❑ Yes ❑ No		

Prescriber signature	Date	Phone	Fax
Prescriber name (print) Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler.			

Parent/Guardian Authorization

☑ I authorize an employee of the school board to administer the above medication. ☑ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. ☑ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.

☑ Medication form must be received by the principal, his/her designee, and/or the school nurse. ☑ I understand that the medication must be in the **original** container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

Parent/Guardian Self-Carry Authorization

❑ *For Epinephrine Autoinjector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.*

❑ *For Asthma Inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.*

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

HEA 7758 5/11

Please fax form to IL School Nurse Kourtney Thompson at 937-686-0049

❑ File per district policy