SPRINGFIELD SCHOOL DISTRICT
CARDIC CARE PLAN

Student's Name:_____ Date of Birth:_____
Parent's/Guardian's Name:_____ Phone: Home:_____
Work:_____
Cell:_____
Primary Physician's Name: _____ Phone:_____
Cardiologist's Name:_____ Phone:_____
Cardiac Condition:_____ Age of diagnosis:_____
Brief description:

_____

_____

Cardiac Testing: Test Date: _____ Stress Exercise test: Normal Abnormal Not Done
Test Date: _____ 24 hr Holter Monitor: Normal Abnormal Not Done
Test Date: _____ Echo test: Normal Abnormal Not Done
Cardiac Procedures/Operations: _____

Most recent appointment with Cardiologist: _____ N/A
Vital signs: Ht._____ Wt. _____ Pulse _____ (regular/irregular) Blood Pressure: _____

Parameters acceptable for school attendance: Heart rate range: _____/minute
Blood pressure range: _____ Respirations: _____/minute

List of current medications:

NAME	DOSE	PURPOSE	SCHEDULE

DRUG ALLERGIES: _____
Other Medical Conditions: _____
_____

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
- ○ Other- Describe:

_____

The following may indicate a worsening of this child's cardiac condition (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:

_____

If student complains of chest pain, shortness of breath and/or has vital signs outside acceptable parameters, School Health Professional should immediately:

1. Check for pulse, respirations, O2 saturation, and level of consciousness
2. Call 911
3. Contact parent/guardian
4. Provide medication prescribed and available at school

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

1. Begin CPR and obtain AED
2. Have someone obtain paperwork with personal information to go with student

I hereby certify that an examination was performed by myself or an individual under my direct supervision with the following conclusion relating to **school attendance** and **participation in extracurricular activities**:

_____Cleared without limitation, including all physical activities and recess.

_____ NOT cleared for: _____

_____

Student Special Considerations: _____

Physician's name (print/type): _____

Address: _____

_____

Physician's signature: _____ Date: _____

Parent's signature: _____ Date: _____