

School year _____

Student legal last name _____ First name _____ MI _____

Birth date _____ School _____ Grade _____ Other ID# _____

Transportation: Walker Self Transported Bus Rider Bus/Route Number _____

Parent/Guardian Information

Parent/Guardian _____ Primary phone _____

Work phone _____ Cell phone _____

Parent/Guardian _____ Primary phone _____

Work phone _____ Cell phone _____

Physician and Hospital Information

Physician Name _____ Phone _____

Preferred Hospital _____ Phone _____

Medical Information

Cardiac Monitor Yes No Defibrillator or Pacemaker Yes No

Current Medications

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Rescue and Maintenance

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Cardiac History

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PE/Activity Guidelines

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Special Precautions

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Emergency Intervention

| Possible Symptoms Observed | | Immediate Response |
|----------------------------|---------------------|-------------------------------------------|
| Chest pain | Palpitations | Nursing assessment (ABC's) Vital signs |
| Dizziness | Dysrhythmia | |
| Sweating | Clubbing of fingers | |
| Shortness of breath | Irritability | |
| Rapid heart rate | Cyanosis | |
| Fear and panic | Fatigue | |

Depending on diagnosis, symptoms could be related to heart transplant rejections or cardiac medication levels rather than congenital or acquired cardiac condition. Because each student's needs are unique to their condition/diagnosis, the nurse must acquire directions from the student's licensed health care provider (LHP) in order to individualize the ECP.

| Severe Symptoms | Immediate Response |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| Fainting or collapse with any known heart condition Extreme chest pain Tachycardia that does not resolve Irregular heart rate Difficulty breathing | CALL 911 Notify Parent Notify School Nurse Notify School Principal Do not leave the student unattended |

Classroom Accommodations - Modifications

Report concerns to parent/guardian for physician follow-up

Emergency Contacts

| | | |
|------------|-------------|--------------------|
| Name _____ | Phone _____ | Relationship _____ |
| Name _____ | Phone _____ | Relationship _____ |
| Name _____ | Phone _____ | Relationship _____ |

| | | |
|---------------------------------|----------------------------------------------------------------------------------------------------------|------------|
| Parent/Guardian Signature _____ | **Original signature required! Please print and sign.** <i>(This notation will not print.)</i> | Date _____ |
| School Nurse Signature _____ | **Original signature required! Please print and sign.** <i>(This notation will not print.)</i> | Date _____ |
| Physician Signature _____ | **Original signature required! Please print and sign.** <i>(This notation will not print.)</i> | Date _____ |

A copy of this plan will be kept in the school office and copies will be given to:

- Para educator
 Transportation
 Teacher
 PE Teacher
 Student Services
 Health Room
 Secretary-Principal

Other _____

CONFIDENTIAL INFORMATION/SHRED PRIOR TO DISCARDING