Student_____DOB_____Teacher_____Year_____

HEART CONDITION ACTION PLAN

Confidential Individualized Health Care Plan

Parent/Guardian, Please answer the questions below regarding your student's Heart Condition.

1. Cause: What causes or can trigger symptoms,

_____

2. Medical Visits: How often does the student seek medical attention for heart condition,
See a doctor _____ times a year
Go to the hospital _____times a year
Miss school _____times a year

3. Activity: Are there any activities that the student can not participate in?

_____

4. What Helps: What does the student do at home to relieve symptoms?

_____

_____

5. Medications: What medication is the student currently taking
Name of medication_____ Dose_____
Name of medication_____ Dose_____
Name of medication_____ Dose_____
Does the student need medication at school ___Yes ___No

Symptoms of Chest Pain / Heart Problems:

*Sensation of chest tightness
*Lips and fingernails are gray or blue
*Difficulty breathing, struggling or gasping for air
*Dizziness/ Lightheaded
*Sense of Doom
*Pain radiating down arms or shoulders.
*Tingling/numbness in fingers/toes/face
*Chest and neck are pulled in with breathing
*Nausea or vomiting

School Personnel Interventions:

***Student should not go to office/nurse unattended**
*Attempt to calm student/stay with student
*Notify school nurse if in the building, if not notify the first responder.
*Have the student lie down or rest in sitting position breathing slowly
*Monitor Pulse and Blood Pressure
*Notify parent of difficulty, and treat as they direct
*If parent is unavailable or student is having extreme pain or loses consciousness, call 911

Space on back of form for additional instructions.

(*Remember if emergency medications are to be given, an additional form is required for medication administration while at school.)

Parent/Guardian Signature: _____Date: _____

School Nurse Signature: _____Date: _____

Please complete back of form and return to school nurse.

Student_____DOB_____Teacher_____Year_____

PARENT/GUARDIAN TO COMPLETE:

Parent/Guardian:_____ Phone: _____

_____ Phone: _____

Health Care Provider: _____ Phone: _____

Medical condition:_____

Additional instructions: _____

_____

SCHOOL NURSE TO COMPLETE:

Date initiated: _____ Date returned:_____

Staff competency required: YES NO If yes, who _____

_____

Copy to staff (date): _____

Notes: _____

_____

I DO NOT WISH TO FILE AN EMERGENCY ACTION PLAN FOR MY CHILD THIS YEAR. I DO REALIZE THAT IF A CRISIS SITUATION ARRISES THEN 911 MAY NEED TO BE ACTIVATED PER SCHOOL POLICY.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

PLEASE RETURN THIS INFORMATION TO THE SCHOOL NURSE