CARDIAC INDIVIDUAL HEALTH PLAN

(Parent/guardian to complete this form)

STUDENT NAME _____ DOB _____ SCHOOL _____

GRADE _____ TEACHER _____ SCHOOL YEAR _____

PARENT/GUARDIAN _____ BEST CONTACT/PHONE NUMBER _____

PHYSICIAN _____ PHONE _____

CARDIOLOGIST _____ PHONE _____

What is the name of your child's cardiac condition?

Please describe your child's cardiac condition.

Has your child ever had a surgery or surgeries for this condition? ☐ Yes ☐ No If yes, please describe:

Does your child take a medication at home every day for this condition? ☐ Yes ☐ No If yes, what medication?

Does your child have a doctor's order for medication for this condition to be given at school, and is the medication at school? ☐ Yes ☐ No

Does your child have a pacemaker? ☐ Yes ☐ No

Has your child needed emergency room treatment for this condition within the past year? ☐ Yes ☐ No
If yes, please describe.

In the event that you cannot be reached, please list the name(s) and phone number(s) of persons who are familiar with your child's condition and have knowledge of how to manage this condition. *Please also add this person(s) to your child's pick-up list in case they may need to pick your child up from school due to their condition.*

Name: _____ Phone Number: _____
Name: _____ Phone Number: _____

Is there anything else you would like school staff to know about your child's condition?

PLEASE NOTE: We recommend talking with your child's doctor to see if they recommend an Emergency Action Plan. Please review the back of this form for steps school staff may take in the event of a medical emergency. These will be followed if your child does not have an Emergency Action Plan at school for this condition.

☐ I give permission for my child, _____, to receive care for the medical condition listed above by designated school staff.

☐ School nurse may share information regarding this condition with my child's doctor.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

SCHOOL NURSE SIGNATURE _____ DATE _____

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STUDENT NAME _____

Note: If student also has an Emergency Action Plan (EAP) for this condition, please refer to the EAP for actions school staff should take instead. Otherwise, follow the steps below.

This student has an EAP: ☐ Yes ☐ No

Symptoms:

- ☐ Racing heart rate
- ☐ Heart palpitations
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Chest pain or discomfort
- ☐ Excessive shortness of breath
- ☐ Unusual fatigue
- ☐ Other: _____

Interventions:

1. Stay with student; student should not leave location or be left alone.
2. Allow student to rest and encourage fluids.
3. Call 911 if unable to arouse. Notify front office to direct EMS to student's location.
4. Call or radio for help if needed. Designated first responder school staff should respond to the student's location, and bring any needed emergency equipment, such as an AED.
5. Notify parents/guardians, or designate another staff member to notify:

   Parent/guardian name: _____ Phone number: _____

   Emergency contact name: _____ Phone number: _____
6. Notify school nurse, if in building. If school nurse is not present, notify upon return or via other communication.

Additional information:

_____

_____

_____

_____

Reference: https://www.chop.edu/news/health-tip/know-warning-signs-how-you-can-prevent-sudden-cardiac-death