Cardiac Care Plan

Student Picture



Student Na	me·
WLMINU UN DOB:	Grade:
	Year:
ANIA SCHOOL DISTRICT School: Teacher:	AUG WOOD &
at a reduction	HEW WILMINGTON
	The transfer of the contract o
Other ID: Walker	Bus Rider Bus Number:
Parent/Guardian:	Hm Dhonor
Address:	Tim Phone.
Guardian 2: Wk Phone:	Cell Phone:
Physician:	Phone:
Preferred Hospital:	Allergies:
HEALTH CONCERN: (Enter o	ilagnosis nere):
Other pertinent information:	
	A CONTRACTOR OF SOME MANAGEMENT
	The telephone and the control of the
	ERGENCY ASSESSMENT/PLAN
GOLDEN RULE: IF found uncons	cious/ unresponsive, initiate CPR/ use Automated External Defibrillator, 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
Palpitations (rapid/ irregular heart bea	parents Lise calming approach
Talpitations (Tapid) irregular heart bea	Use calming approach
and the second second contracts.	Attempt to check heart rate agree in incidence and indemnity the Miles and indemnity the Miles.
	If symptoms persist (palpitations continue despite above) call 911.
	If symptoms improve call parents to the feeting to the second to the sec
Chest pain	Use calming approach
	Have patient lie down
E E	If severe and having dizziness or shortness of breath associated with chest
	pain, call 911 Amount of Medication received
	If moderate and persists longer than 10 minutes, call 911 • Notify parents
Bleeding/ severe bruising (for patients	Notify parents immediately
on anticoagulant therapy	If patient expericences 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 27 25 2000 mm and address and address are address.
Parent:	Date:
School Nurse RN:	Date:

CONFIDENTIAL INFORMATION

SHRED PRIOR TO DISCARD

WILMINGTON APEA SCHOOL DISTRICT

Cardiac Care Plan

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Student Name:		त्रम्पाः सर्वे १९७३६ ४,६०५,४,६५ ५,५,५,५,५,५,५,५,५,५,५,५,५,५,५,५,५,५,	
DOB:		Grade: #18 Onto	
School:	, ,	Year: School	
Teacher:		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	

Congenital Heart Defects

Aortic stenosi	is	Atrial Septal Defect (ASD)	
Atrioventricul	ar Septal Defect (AVSD/ AV can		ous
Double Inlet	Left Ventricle	Double Outlet Right Ventricle	
Ebstein's Malf	formation	Hypoplastic Left Heart Syndrome (HLHS	5)
Mitral Stenosi	is/ Insufficiency	Patent Ductus Arteriosus (PDA)	
Pulmonary At	resia	Pulmonic Stenosis/ Insufficiency	
Tetralogy of F	Fallot (TOF)	Coarctation or the Aorta	THE A STATE OF THE PARTY OF THE
Transposition	of the Great Arteries (TGA)	Tricuspid Atresia	
Truncus Arter	riosus	Ventricular Septal Defect (VSD)	and the second s
	<u>Acqui</u>	ired Heart Conditions	the state of the s
Cardiomyopa		Congestive Heart Failure	
Endocarditis		Kawasaki's	
Rheumatic He	eart Disease	Cardiac Transplant	
	Abno	ormal Heart Rhythms	
Atrial Tachyca	ardia	Atrial Flutter	
Long QT Synd	drome (LQTS)	Wolff- Parkinson- White Syndrome (WF	PW)
Supraventricu	ılar Tachycardia	Ventricular Tachycardia (VT)	If symptoms impro-
Other:			perents
		Cardiac Devices	ः । अस्यायम् सम्ब
Pacemaker		Implantable Cardiac Defibrillator (ICD)	Substant Luden
Prosthetic He	art Valve (Aortic, Mitral)	ASD/ VSD Occlusion Device	Automot to check
PDA Occlusion	n Device	Other:	if management
		· ·	e entrituiris and
Date	Sı	urgical/ Interventional Procedures	— Al All biy A ppics — Varaiasianda da
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			Laboration (12)
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Dath Madiantia		•	

Daily Medications:

Cardiac Medications	Dose	Frequency	Common Side Effects
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Student Picture

WILMINGTON AREA SCHOOL DISTRICT

Cardiac Care Plan

Student Name:	() () () () () () () () () ()	ić.
DOB:	an a	
School:	Year:	
Teacher:	The Alives Helical Commen	
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School Nurse Si	ignature:		Print name:	64.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2
Start date:		End date: (not to exceed current school year)		:SE; ::::: cenei;
Date:		Telephone:	Fax:	

PARENT:

- I have reviewed the information on this School Cardiac Care Plan and Medication Orders and request/authorize the school nurse to provide this care and administer the medications in accordance with the Nurse Practice Act.
- 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 licensed health care provider.
- I authorize the exchange of medical information about my child's cardiac condition between the physician's office and school nurse.

The provider's office is encouraged to fax the plan to the student's school nurse. School nurse fax:

Parent/Guardi	an Signature				
		dent will be notified of t	he student's health o	ondition and treatment guidelines.	
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	1				Catar De
	,			- Pacemerer	
3 931 ÷				Provident Heart Valver (Auric, Mitral) PDA Occlusion Davics	
				tie	Seeniral/Teac
1 with chest-					
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forces for the try				Daliy Medications:	
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Student Picture :

WILMINGTON AREA SCHOOL DISTRICT

Cardiac Care Plan

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Student Name:		E.S	
OOB:	Grade: ₩	2 M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
School:	The Year: William	ry I Stireot.	
Гeacher:	A Armada		
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RECOMMENDATIONS FOR PHYSICAL ACTIVITY

The following recommendations are guidelines for physical activity for:

climbing, weight lifting, sustained running (e.g. laps) and fitness testing. • Must be allowed to rest when tired. • No JV/ varsity/ competitive sport participation. 4 • May participate in mild PE class activities such as circle games, golf, and badminton • No recreational, JV or varsity sports. 5 • Restricted from entire PE class program and all recreational, JV, or varsity sports. Duration of recommendations: Additional remarks: For District Nurse's Use Only ations received: Amount received: Date Date pysician gnature: positions Date propositions Date pysician	Patient	Name:						
May participate in the entire physical education program (PE class) without—restriction, including all junior varsity (JV) and varsity competitive sports. May participate in the entire PE program. May not participate in the JV/ varsity competitive sports where there is strenuous training and prolonged physical exertion (e.g. football, hockey, wrestling, lacrosse, soccer, basketball). Less strenuous sports such as baseball and golf are acceptable at the JV/ varsity level. May participate in the PE class except for excessively stressful activities such as rope climbing, weight lifting, sustained running (e.g. laps) and fitness testing. Must be allowed to rest when tired. No JV/ varsity/ competitive sport participation. May participate in mild PE class activities such as circle games, golf, and badminton No recreational, JV or varsity sports. Puration of recommendations: Additional remarks: For District Nurse's Use Only Amount received: Amount received: Date Date ysician gnature: Date	Date of	Exam:				71		
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inc.		·		Phone:				

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Student Picture

WILMINGTON AREA SCHOOL DISTRICT

400 WOOD STREET NEW WILMINGTON, PA 16142

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Building	DOB
Name of Medication (A separate for administered)	
Desired time of administration	
Special circumstances of Side effect	ts.
Listing of other medications prescrib	ped for student
Prescribing Physician's Name	is prescribed
Prescribing Physician's Name Prescribing physician's signature OR	copy of signed prescription attached
Prescribing Physician's Name Prescribing physician's signature OR	copy of signed prescription attachedOR
Prescribing Physician's Name Prescribing physician's signature OR Signed Prescription attached: I hereby agree to hold harmless and i employees against any and all claims causes of action in law or equity for the	copy of signed prescription attached OR indemnify the Wilmington Area School District and its a damages, expenses, attorney's fees, suits, cause or ne administration of the medication authorized above.
Prescribing Physician's Name Prescribing physician's signature OR Signed Prescription attached: I hereby agree to hold harmless and i employees against any and all claims causes of action in law or equity for the Printed Name of Parent/Guardian	OR indemnify the Wilmington Area School District and its
Prescribing Physician's Name Prescribing physician's signature OR Signed Prescription attached: I hereby agree to hold harmless and i employees against any and all claims causes of action in law or equity for the	copy of signed prescription attached OR indemnify the Wilmington Area School District and its damages, expenses, attorney's fees, suits, cause or ne administration of the medication authorized above. Signature of Parent/Guardian Date
Prescribing Physician's Name Prescribing physician's signature OR Signed Prescription attached: I hereby agree to hold harmless and i employees against any and all claims causes of action in law or equity for the Printed Name of Parent/Guardian amount of Medication received	copy of signed prescription attached OR indemnify the Wilmington Area School District and its a damages, expenses, attorney's fees, suits, cause or ne administration of the medication authorized above.
Prescribing Physician's Name Prescribing physician's signature OR Signed Prescription attached: I hereby agree to hold harmless and i employees against any and all claims causes of action in law or equity for the Printed Name of Parent/Guardian	copy of signed prescription attached OR indemnify the Wilmington Area School District and its damages, expenses, attorney's fees, suits, cause or ne administration of the medication authorized above. Signature of Parent/Guardian Date

CONFINENTIAL Page 6 of 6 ON

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KHR.F.D.

Emergency Care Plan

Name:	DOB:
School:	
Parent/Guardian Emergency Contact:	
Telephone (h):(w):	
Parent/Guardian Emergency Contact:	
Telephone (h):(w):	(cel)
Emergency Contact (if Parent/Guardian not available)/	
Healthcare Provider/Telephone:	
KNOWN ALLERGIES:	
HEALTH PROBLEM:	
IN A HEALTH EMERGENCY (STUDENT) LOOKS I	
PLEASE DO THE FOLLOWING:	
Devent/Cuardian Signature	
Parent/Guardian Signature:	`
Certified School Nurse Signature:	Date: