Cardiac Care Plan

Student Picture

WILMINGTON AREA SCHOOL DISTRICT

Student Name: _____

DOB: _____ Grade: _____

School: _____ Year: _____

Teacher: _____

Other ID: _____ Walker ☐ Bus Rider ☐ Bus Number: _____

Parent/Guardian: _____ Hm Phone: _____

Address: _____

Guardian 1: Wk Phone: _____ Cell Phone: _____

Guardian 2: Wk Phone: _____ Cell Phone: _____

Physician: _____ Phone: _____

Preferred Hospital: _____ Allergies: _____

HEALTH CONCERN: (Enter diagnosis here) :

Other pertinent information:

EMERGENCY ASSESSMENT/ PLAN

GOLDEN RULE: IF found unconscious/ 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 parents
Palpitations (rapid/ irregular heart beat)	• Use calming approach • Reassure student • Attempt to check heart rate • If symptoms persist (palpitations continue despite above) call 911 • If symptoms improve call parents
Chest pain	• Use calming approach • Have patient lie down • If severe and having dizziness or shortness of breath associated with chest pain, call 911 • If moderate and persists longer than 10 minutes, call 911 • Notify parents
Bleeding/ severe bruising (for patients on anticoagulant therapy	• Notify parents immediately • 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

Parent: _____ Date: _____

School Nurse RN: _____ Date: _____

CONFIDENTIAL INFORMATION SHRED PRIOR TO DISCARD

WILMINGTON AREA SCHOOL DISTRICT

Cardiac Care Plan

Student Picture

Student Name: _____

DOB: _____ Grade: _____

School: _____ Year: _____

Teacher: _____

Congenital Heart Defects

_____ Aortic stenosis
_____ Atrioventricular Septal Defect (AVSD/ AV canal)
_____ Double Inlet Left Ventricle
_____ Ebstein's Malformation
_____ Mitral Stenosis/ Insufficiency
_____ Pulmonary Atresia
_____ Tetralogy of Fallot (TOF)
_____ Transposition of the Great Arteries (TGA)
_____ Truncus Arteriosus
_____ Atrial Septal Defect (ASD)
_____ Total/ Partial Anomalous Pulmonary Venous Return (TAPVR/ PAPVR)
_____ Double Outlet Right Ventricle
_____ Hypoplastic Left Heart Syndrome (HLHS)
_____ Patent Ductus Arteriosus (PDA)
_____ Pulmonic Stenosis/ Insufficiency
_____ Coarctation or the Aorta
_____ Tricuspid Atresia
_____ Ventricular Septal Defect (VSD)

Acquired Heart Conditions

_____ Cardiomyopathy
_____ Endocarditis
_____ Rheumatic Heart Disease
_____ Congestive Heart Failure
_____ Kawasaki's
_____ Cardiac Transplant

Abnormal Heart Rhythms

_____ Atrial Tachycardia
_____ Long QT Syndrome (LQTS)
_____ Supraventricular Tachycardia
_____ Other: _____
_____ Atrial Flutter
_____ Wolff- Parkinson- White Syndrome (WPW)
_____ Ventricular Tachycardia (VT)

Cardiac Devices

_____ Pacemaker
_____ Prosthetic Heart Valve (Aortic, Mitral)
_____ PDA Occlusion Device
_____ Implantable Cardiac Defibrillator (ICD)
_____ ASD/ VSD Occlusion Device
_____ Other: _____

Date	Surgical/ Interventional Procedures

Daily Medications:

Cardiac Medications	Dose	Frequency	Common Side Effects

WILMINGTON AREA SCHOOL DISTRICT

Cardiac Care Plan

Student Picture

Student Name:	
DOB:	Grade:
School:	Year:
Teacher:	

School Nurse Signature:	Print name:	
Start date:	End date: (not to exceed current school year)	Last day of school Other:
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/Guardian Signature

Staff who are involved with the student will be notified of the student's health condition and treatment guidelines.

Daily Medications:

CONFIDENTIAL INFORMATION SHRED PRIOR TO DISCARD

WILMINGTON AREA SCHOOL DISTRICT

Cardiac Care Plan

Student Picture

Student Name: _____

DOB: _____ Grade: _____

School: _____ Year: _____

Teacher: _____

RECOMMENDATIONS FOR PHYSICAL ACTIVITY

The following recommendations are guidelines for physical activity for:

Patient Name: _____

Date of Exam: _____

	ACTIVITY LEVEL	Initial
1	• May participate in the entire physical education program (PE class) without restriction, including all junior varsity (JV) and varsity competitive sports.	
2	• 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.	
3	• 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.	
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

Medications received: Amount received:

School Nurse Signature **Date**

_____

_____

_____

_____

Physician Signature: _____ Date _____

Physician Name: _____ Phone: _____ FAX: _____

CONFIDENTIAL INFORMATION **SHRED PRIOR TO DISCARD**

WILMINGTON AREA SCHOOL DISTRICT

400 WOOD STREET
NEW WILMINGTON, PA 16142

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Student's Name _____ DOB _____

Building _____ Grade/Homeroom _____

Name of Medication (A separate form must be completed for EACH medication that is to be administered) _____

_____

Dosage _____

Desired time of administration _____

Special circumstances of Side effects _____

Listing of other medications prescribed for student _____

_____

Period of time for which medication is prescribed _____

Prescribing Physician's Name _____

Prescribing physician's signature OR copy of signed prescription attached

_____ OR

Signed Prescription attached: _____

I hereby agree to hold harmless and indemnify the Wilmington Area School District and its employees against any and all claims, damages, expenses, attorney's fees, suits, cause or causes of action in law or equity for the administration of the medication authorized above.

_____ _____ _____

Printed Name of Parent/Guardian Signature of Parent/Guardian Date

Amount of Medication received _____

_____

By _____ _____

Signature Date

NOTE: ALL MEDICATION MUST BE BROUGHT TO SCHOOL IN THE ORIGINAL PRESCRIPTION/MANUFACTURER'S BOTTLE OR IT WILL NOT BE ADMINISTERED AT SCHOOL.

Emergency Care Plan

Name:_____ DOB:_____

School:_____ Grade:_____

Parent/Guardian Emergency Contact:_____

Telephone (h):_____(w):_____(cel)_____

Parent/Guardian Emergency Contact:_____

Telephone (h):_____(w):_____(cel)_____

Emergency Contact (if Parent/Guardian not available)/Relationship/Telephone Number:

_____

Healthcare Provider/Telephone:_____

KNOWN ALLERGIES:_____

_____

HEALTH PROBLEM:_____

IN A HEALTH EMERGENCY (STUDENT) LOOKS LIKE:

_____

_____

_____

PLEASE DO THE FOLLOWING:

_____

_____

_____

_____

_____

Parent/Guardian Signature:_____Date:_____

Certified School Nurse Signature:_____Date:_____