

## Cardiac Care Plan

Student Picture

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 experiences 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: \_\_\_\_\_

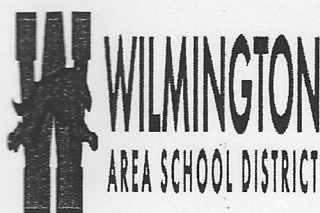
Date: \_\_\_\_\_

School Nurse RN: \_\_\_\_\_

Date: \_\_\_\_\_

CONFIDENTIAL INFORMATION

SHRED PRIOR TO DISCARD



# Cardiac Care Plan

Student Picture \_\_\_\_\_

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

## Congenital Heart Defects

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

## Acquired Heart Conditions

- |  |   |
|--|---|
| <input type="checkbox"/> Cardiomyopathy          | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Endocarditis            | <input type="checkbox"/> Kawasaki's               |
| <input type="checkbox"/> Rheumatic Heart Disease | <input type="checkbox"/> Cardiac Transplant       |

## Abnormal Heart Rhythms

- |   |   |
|---|---|
| <input type="checkbox"/> Atrial Tachycardia           | <input type="checkbox"/> Atrial Flutter                         |
| <input type="checkbox"/> Long QT Syndrome (LQTS)      | <input type="checkbox"/> Wolff- Parkinson- White Syndrome (WPW) |
| <input type="checkbox"/> Supraventricular Tachycardia | <input type="checkbox"/> Ventricular Tachycardia (VT)           |
| <input type="checkbox"/> Other: _____                 |   |

## Cardiac Devices

- |  |  |
|--|--|
| <input type="checkbox"/> Pacemaker                               | <input type="checkbox"/> Implantable Cardiac Defibrillator (ICD) |
| <input type="checkbox"/> Prosthetic Heart Valve (Aortic, Mitral) | <input type="checkbox"/> ASD/ VSD Occlusion Device               |
| <input type="checkbox"/> PDA Occlusion Device                    | <input type="checkbox"/> Other: _____                            |

Date	Surgical/ Interventional Procedures

## Daily Medications:

Cardiac Medications	Dose	Frequency	Common Side Effects

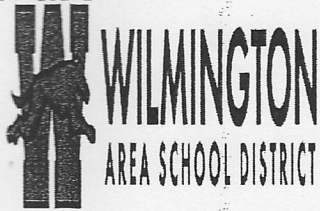
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## Cardiac Care Plan

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	<ul style="list-style-type: none"><li>May participate in the entire physical education program (PE class) without restriction, including all junior varsity (JV) and varsity competitive sports.</li></ul>	
2	<ul style="list-style-type: none"><li>May participate in the entire PE program.</li><li>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).</li><li>Less strenuous sports such as baseball and golf are acceptable at the JV/ varsity level.</li></ul>	
3	<ul style="list-style-type: none"><li>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.</li><li>Must be allowed to rest when tired.</li><li>No JV/ varsity/ competitive sport participation.</li></ul>	
4	<ul style="list-style-type: none"><li>May participate in mild PE class activities such as circle games, golf, and badminton</li><li>No recreational, JV or varsity sports.</li></ul>	
5	<ul style="list-style-type: none"><li>Restricted from entire PE class program and all recreational, JV, or varsity sports.</li></ul>	

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: \_\_\_\_\_

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**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: \_\_\_\_\_