Cardiac Action Plan

This Action Plan is to be completed and signed by the child's parent/guardian and physician. The information on this plan is confidential. All staff involved in the care of your child will have access to this information in order to provide the optimal safety in the school setting. Please contact the school nurse at any time if you need to update this Action Plan.

Student Name_____DOB_____Class/Homeroom_____

Parent/Guardian_____Phone #_____

Parent/Guardian_____Phone #_____

Physician treating student for cardiac issues_____Phone#_____

Other Physicians_____

_____

Cardiac Diagnosis(es)_____

_____

Cardiac Surgeries/Dates_____

_____

- **Cardiac Symptoms**_____
- **Cardiac Warning Signs**_____

Special Equipment/Activity Restrictions

- Does this student have any internal or external equipment to consider in the school setting?____
  - ☐ If Yes, please describe_____
    (Parent will provide supplies/equipment)

- Is student allowed to participate in physical education or other activities at school?
  - ☐ Yes, may fully participate
  - ☐ No, please explain/list limitations_____

    _____

Prevention Measures

- List any environmental control measures or dietary restrictions the student requires to aid in preventing a cardiac episode _____

_____

Medications

Medication Name	Dosage, Route, Time of Day Given	Side effects/Special Instructions

Emergency Response

- A "Cardiac Emergency" for this student is defined as_____

_____

_____

Emergency Medications

Emergency Medication Name	Dosage, Route, Frequency	Side Effects/Special Instructions

Other Instructions_____

_____

Physician Name_____**Signature**_____**Date**_____

Parent Name_____**Signature**_____**Date**_____

School Nurse Name_____**Signature**_____**Date**_____