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**Beth Schutte, R.N.**  
District School Nurse

## CARDIAC CONDITION MEDICAL MANAGEMENT PLAN

Dear Parents or Guardian:

This plan should be completed by the student's physician and parents/guardian. Please have the physician to give guidelines on type of cardiac distress and treatment protocol, so that the school staff will be clear on what is to be done.

Please also have the physician complete the attached form "Permission to Administer Medication" if medication is to be given at school. Please send all medication in original labeled container from the pharmacy.

Each school year this plan must be completed by the student's physician and parents/guardian. If you have any questions or concerns, please call the Nurse or Health Aide in your child's school.

Thank you,  
Beth Schutte, R.N.  
District School Nurse for Haysville Schools

## Cardiac Condition Individual Health Plan (IHP)



**Date Plan Effective:**

**Parent to Complete**

Name:		Date of Birth:	
School / Grade:		Room / Teacher:	
Parent / Guardian:			
Mother's phone	Home:	Work:	Cell:
Father's phone	Home:	Work:	Cell:
Health Care Provider:	Phone:	Fax:	
Brief history of diagnosis:			
Recent hospitalizations:			
Concurrent illness or disability:			

### Signs and Symptoms of Cardiac Distress

<b>Mental</b>	States feels "scared"; something bad is going to happen/ unconscious
<b>Pain</b>	Chest Pain
<b>Breathing</b>	Shortness of breath
<b>Skin</b>	Grey/blue color
<b>Other</b>	

**NEVER SEND STUDENT WITH ANY SYMPTOMS ANYWHERE ALONE**

### Health Care Provider to Complete

Please indicate if condition is life threatening:

No, this condition is not life threatening. No intervention is needed at this time.  
(Thank you for your time. Please sign on back page.)

Yes, this is a life threatening condition. A medication/treatment plan is needed. (Continue below)

### Treatment at School, unless otherwise indicated by Health Care Provider:

Minor Cardiac Symptoms and Management	Severe Cardiac Distress and Management
<p><b>Chest pain:</b></p> <ul style="list-style-type: none"> <li>• Allow to rest in health room in whichever position is most comfortable.</li> <li>• If the school nurse is on-site, vital signs will be promptly checked.</li> <li>• If pain persists longer than ____ minutes or gets worse, contact a parent or relative.</li> <li>• Other _____</li> </ul> <p><b>Shortness of breath:</b></p> <ul style="list-style-type: none"> <li>• Encourage to lean slightly forward and breathe through pursed lips.</li> <li>• If breathing is not normal in ____ minutes, contact a parent or relative.</li> <li>• Other _____</li> </ul>	<p><b>Main Symptoms of Cardiac Distress</b></p> <ul style="list-style-type: none"> <li>• Sudden severe chest pain</li> <li>• Sudden onset of severe shortness of breath</li> <li>• Loss of consciousness</li> <li>• Other _____</li> </ul> <p><b>Treatment of Cardiac Distress</b></p> <ul style="list-style-type: none"> <li>• Call 911</li> <li>• Stay with student</li> <li>• Begin CPR if the need arises</li> <li>• Have another school employee contact parents</li> <li>• Contact school nurse if not in the building at time of incident</li> </ul> <p>Other _____</p>

**Classroom Information/ Accommodations:**

- No  Yes Go outside during **regular recess periods** & walk, run, play at own pace as tolerated.
- No  Yes Remain inside during severe cold weather.
- No  Yes Remain in the shade when temperature is over 90 degrees.
- No  Yes Participate in regular P.E.
- No  Yes Participate in competitive or contact sports.
- No  Yes Participate in a group run over a prescribed distance \_\_\_\_\_ miles.
- No  Yes Permit student to rest, sit, squat, or lie down, whenever necessary.
- No  Yes Bathroom access as needed
- No  Yes Dietary restrictions: \_\_\_\_\_

Other: \_\_\_\_\_

**School Bus Driver Instructions (as needed):**

**Field Trip Accommodations (as needed):**

- All medications/supplies are taken and care is provided (Mark one)
  - By accompanying parent
  - By the student, if self - managing
  - By accompanying designated school staff per district medication policies and orders

**Extra-Curricular Activities Accommodations (as needed):**

- All medications/supplies are taken and care is provided (Mark one)
  - By accompanying parent
  - By the student, if self - managing
  - By accompanying designated school staff per district medication policies and orders

**Disaster Planning:**

Health Care Provider Signature:	Date:
Parent Signature:	Date:
School Nurse Signature:	Date:

Date Reviewed with Parent

Date/Nurse Signature	Date/Nurse Signature	Date/Nurse Signature	Date/Nurse Signature	Date/Nurse Signature