Haysville Public Schools Cardiac Action Plan and Medication Orders

Student's Name:	Birthdate:	Grade:
School:	Teacher:	
Primary Care Physician / Phone**:**		
Cardiologist / Phone:		
Preferred Hospital:		

TO BE COMPLETED BY HEALTH CARE PROVIDER

Cardiac Information

Diagnosis:	
Last Cardiac Event:	
Warning Signs:	
Cardiac Surgeries:	
Internal/External Equipment:	
Cardiac Emergency for this student is defined as:	

Please list any medications student is presently taking for cardiac care:

Medication	Dose	Time	Route	Give at School	Give at Home

Special Considerations and Precautions

Gym/Sports/Classroom restrictions: _____

_____

_____

School Trips: _____

Other: _____

Medical Provider: Your signature serves as the medical order for this plan of care including medication administration as outlined on this care plan.

_____ _____ _____

Physician Signature | Physician Name (print) | Date

Student Name: _____ DOB: _____

Treatment at school, unless otherwise indicated by health care provider:

Minor Cardiac Symptoms and Management	Severe Cardiac Distress and Management
Chest Pain: • Allow to rest in health room in whichever position is comfortable • School health staff will check vital signs • Parents may need to be contacted by health staff **Shortness of breath:** • Encourage to lean slightly forward and breathe through pursed lips. • School health staff will monitor vital signs • Parents may need to be contacted by health staff	**Main Symptoms of Cardiac Distress:** • Sudden severe chest pain • Sudden onset of severe shortness of breath • Loss of consciousness • Other: _____ **Treatment of Cardiac Distress:** • Call 911 • Stay with student • Apply AED / Begin CPR if need arises • Have another employee contact parents • Contact school health staff

1. Parent:	Phone Number:
2. Emergency contacts: Name/Relationship	Phone Number(s)
a.	
b.	

I grant permission for Haysville Schools to exchange information with my child's health care provider and dispensing pharmacy identified on the medication label as deemed necessary. I hereby request that Haysville schools cooperate with the prescribing health care provider and assist with the administration of medication pursuant to the policy of the Haysville Schools. I have reviewed the above statements and agree to abide by Haysville Schools School District Policy regarding the administration of medication/procedures at school. I further release Haysville schools and school personnel from liability when my child self-carries and self-administers medication.

Parent/Guardian Signature: _____ Date: _____

School Nurse: _____ Date: _____