Effingham CUSD #40·2803 S. Banker, PO Box 130·Effingham, IL 62401

Cardiac Individual Health Care Plan for school year _____

STUDENT NAME: _____ DOB: _____ GRADE: _____

TEACHER: _____ MEDICATION ALLERGIES: _____

CHECK TYPE OF CARDIAC CONDITION

- Atrioventricular Septal Defect (AVSD) ☐
- Atrial Septal Defect (ASD) ☐
- Ventricular Septal Defect ☐
- Cardiomyopathy ☐
- Endocarditis ☐
- Rheumatic Heart Disease ☐
- Congestive Heart Failure (CHF) ☐
- Kawasaki's ☐
- Cardiac Transplant ☐
- Atrial Tachycardia ☐
- Long QT Syndrome ☐
- Supraventricular Tachycardia ☐
- Atrial Flutter ☐
- Atrial Fibrillation ☐
- Wolff-Parkinson-White Syndrome ☐
- Ventricular Tachycardia ☐
- Murmur _____ ☐
- Other: _____ ☐

SYMPTOMS MY CHILD MAY EXPERIENCE (CHECK)

- Dizziness ☐
- Fainting ☐
- Shortness of breath ☐
- Palpitations ☐
- Chest Pain ☐
- Bleeding/Severe Bruising (from anticoagulation therapy) ☐
- Clammy/Cool skin ☐
- Confusion ☐
- Skin color changes (lips/mouth/ nail bed/skin ☐
- Feeling of "doom" or scared ☐
- Other (please explain) ☐

_____

_____

_____

SURGICAL HISTORY/DATES: _____

_____

DAILY MEDICATIONS: _____

DISASTER MEDICATIONS: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ PH: _____

NAME: _____ PH: _____

NAME: _____ PH: _____

☐ My child has restrictions (attach physician order) ☐ My child has **NO** restrictions

EMERGENCY ASSESSMENT/PLAN

If you see the following:	What to do:
Chest Pain	• Use calming approach • Have student lie down • Call nurse-obtain vital signs • If severe and having dizziness or shortness of breath, call 911 • If moderate and persists longer than ____minutes, call 911 • Notify parents
Shortness of Breath	• Sit student and encourage purse lipped breathing • Call nurse • If breathing is not normal in ____ minutes, contact 911 • Notify parents • Other _____
Dizziness/feeling faint	• Have student lie down and elevate legs • Call nurse • Attempt to check heart rate • If symptoms persist (still dizzy/can't sit up) call 911 • If symptoms improve, offer fluids and notify parents
Palpitations (rapid/irregular heart beat)	• Use calming approach • Reassure student • Call nurse • Attempt to check heart rate • If symptoms persist, call 911 and parents • If symptoms improve notify parents
Bleeding/severe bruising (for students on anticoagulation therapy)	• Notify Nurse • Notify Parents Immediately • If student experience injury to head/abdomen, complaints of back/belly pain, or coughing/ urinating/vomiting blood, call 911. • For minor cuts/light bleeding, provide first aid

***If student loses consciousness and is absent of respirations or pulse, begin CPR immediately, obtain AED and contact 911

I have reviewed the information on the care plan. I give the health services staff and school administrators permission to communicate with my child's licensed health care provider about any medical treatment/medication orders that I provide to the school, in accordance with the HIPPA/FERPA regulations. I understand that the school may share this care plan with school staff and emergency responders if student requires emergency services. If medication is prescribed within this plan, the medication is to be furnished by me in the original container, and BROUGHT TO SCHOOL BY AN ADULT. Prescription medication must be labeled by the pharmacy with the name of the patient, health care provider, medication, dosage, and the time of day to be given. I understand medication may be administrated by non-licensed trained designated staff members in accordance with the state regulations and district policy. I understand that at the end of the school year, an adult must pick up any medication, otherwise it will be discarded.

PARENT SIGNATURE: _____ DATE: _____

HEALTH CARE PROVIDER SIGNATURE: _____ DATE: _____