CARDIAC Individualized Healthcare Plan/Emergency Care Plan			School Year	Picture
STUDENT INFORMATION				
Student:	DOB:	Grade:	School:	
Parent:	Phone: 8		Email:	
Physician:	Phone:		Fax:	

BRIEF MEDICAL HISTORY

Medical Diagnosis:

Specific Concerns to be addressed at school:

Parent: complete the above section, read and sign below, obtain signature from Health Care Provider, and return to school nurse. No accommodations can be made until signed IHP/EAP, medication order, or IEP/Section 504 Plan are on file with the school.

As parent/guardian of the above named student, I give permission for my child's healthcare provider to share information with the school nurse for the completion of this plan. I understand the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the School Nurse of any change in the student's health status, care or medication order. Parents/Guardian are responsible for maintaining necessary supplies, medications and equipment.

Parent Signature:	**Date:**

EMERGENCY CARE PLAN

Warning Signs and Symptoms of Cardiac Problems

▪Decreased level of consciousness ▪Shortness of breath ▪Chest pain or Pressure ▪Clammy, cool skin ▪Seizures ▪Swelling of the abdomen, legs or feet ▪Fainting or Dizziness ▪Fatigue or Marked Weakness ▪Numbness or Tingling ▪Alteration in Speech, Vision, Hearing, Balance, Coordination ▪Pale or Bluish skin color ▪Vomiting ▪Headaches ▪Trembling ▪List Others:

If you see this	***Do This***
*If student experiences any of the above symptoms but is **conscious, alert,** and in **no apparent urgent distress**:*	1.Assist student to seated or lying position. 2.Have student take slow deep breaths 3.Call parent immediately. 4.Student should never be alone when having symptoms.
*If student is **unconscious, unresponsive, faints**, or has **difficulty breathing**:*	1.Call 911 immediately. 2.Send someone to retrieve AED 3.Trained Personnel may administer CPR. ***Use AED ONLY if necessary***. 4.Provide this plan to EMS. 5.Student should never be alone when having symptoms. 6.Notify parent and district nurse.

SPECIAL ACCOMMODATIONS, RESTRICTIONS, OR PRECAUTIONS DURING SCHOOL

☐ **None**	☐ **Learning** ☐ **PE** ☐ **Recess**	☐ **Transportation** ☐ **Toileting** ☐ **Other:**	☐ **Meals*** **Special Meal Accommodation Request Form Required*

ROUTINE MEDICATIONS AT SCHOOL

☐ **NO** ☐ **YES*** ***COMPLETE MEDICATION AUTHORIZATION FORM IF MEDICATION AT SCHOOL****

PHYSICIAN SIGNATURE

The above named student is under my care. I recommend the above special accommodations, restrictions, and/or precautions for school.

Physician Signature:	**Date:**

SCHOOL NURSE

Individualized Healthcare Plan/Emergency Care Plan (this form) distributed to 'need to know' staff:
☐Front office/admin ☐ Teacher(s) ☐ Transportation ☐ Other (specify):

School Nurse Signature:	Date: