

CARDIAC INDIVIDUALIZED HEALTH PLAN

Name: _____ Date of Birth: _____ Grade: _____
Parent/Guardian Name: _____ Phone: Home Cell _____ Work _____
Emergency Contact: _____ Relationship: _____ Phone: Home Cell _____

Primary Physician's Name: _____ Phone: _____
Cardiologist's Name: _____ Phone: _____

Cardiac History and Assessment

Cardiac Condition: _____ Age at diagnosis: _____
Brief description: _____

Open Heart Surgery: No Yes Date: _____ Procedure: _____

CARDIAC TESTING

TEST	DATE	RESULTS		
Stress Exercise Test		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not Done
24 Hour Holter Monitor		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not Done
Echo		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not Done
Other:		<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	

Most recent appointment with Cardiologist: _____ N/A
Vital Signs: Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Regular Irregular

Parameters acceptable for school attendance: Heart Rate Range: _____ /minute

Blood pressure range: _____ Respirations: _____ /minute

If student complains of chest pain, shortness of breath and/or has vital signs outside of acceptable parameters School Health Professional should immediately:

- Call 911 Contact Parent/Guardian Provide medication prescribed and available at school
 Other: _____

I hereby certify that an examination was performed by myself or an individual under my direct supervision with the following conclusion relating to school attendance and participation in extracurricular activities:

- Cleared without limitation, including all physical activities and recess
 Allowed to swim One on one supervision only Shallow end only
 Not cleared for: _____

Recommendations _____

Name of Physician Completing Form (print/type): _____

Address: _____ City: _____ Phone: _____

Signature of Physician: _____ Date: _____

I hereby give permission for this Individualized Health Plan to be shared with appropriate school staff on a need to know basis. I read, understand and agree with the above plan. I will notify the school nurse in writing if there are any changes in this plan. The school nurse may communicate with the above physician via telephone and/or fax.

Parent's Signature: _____ Date: _____