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		❒ Normal ❒ Abnormal ❒ Not Done
24 Hour Holter Monitor		❒ Normal ❒ Abnormal ❒ Not Done
Echo		❒ Normal ❒ Abnormal ❒ Not Done
Other:		❒ Normal ❒ 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: _______________