

CARDIAC EMERGENCY ACTION PLAN/504

Place student picture here

NAME:		Birthdate:		Teacher:	
Grade:		School:		<input type="checkbox"/> Bus #	
				<input type="checkbox"/> Walk	<input type="checkbox"/> Drive
Doctor:		Phone:		Fax:	
Preferred Hospital:					
Cardiac Condition/Concern:					

Wears medical alert bracelet? YES NO

Action:

- **If symptoms worsen, are not immediately relieved, or when unsure CALL 9-1-1 for evaluation**
- Allow student to rest in position of comfort
- Alert (designated staff) knowledgeable in CPR to sit with student
- Contact parent, notify school nurse
- Always print out contact information for current phone numbers

Additional information from LHP:

LHP Signature	Date	Telephone: Fax Number:
LHP Printed Name	Start Date:	End Date:

PARENT/GUARDIAN SECTION

EMERGENCY CONTACTS

Name
Home Phone
Work Phone
Other

Name
Home Phone
Work Phone
Other

ADDITIONAL EMERGENCY CONTACTS:

1.	Relationship:	Phone:
2.	Relationship:	Phone:

****Does the student need classroom, school activity, or recess accommodations? ___yes ___no. If yes, please contact the school counselor.**

- A new health care plan for cardiac conditions must be submitted each school year.
- I understand that if any changes are needed on the HCP, it is the parent's responsibility to contact the school nurse.
- It is the parent's responsibility to alert all other non-school programs of their child's health condition.
- Medical information may be shared with school staff working with your child and 911 staff, if they are called.
- I have reviewed the information on this health care plan and medication order and request/authorize trained school employees to provide this care and in accordance with the Licensed Healthcare Provider's (LHP's) instructions.
- I understand this plan can only be discontinued by the LHP.
- I authorize the exchange of information about my child's cardiac condition between the LHP office and the school nurse.
- *My signature below shows I have reviewed and agree with this health care plan.*

Parent/Guardian Signature _____

Date _____

For District Nurse's Use Only		
School Nurse Signature	Date	Phone:

Health care plan and medication (if prescribed) must accompany student on any field trip or school activity.

****Keep plan readily available for substitutes.****