SEEKONK PUBLIC SCHOOLS

Cardiac Care Plan

Student's Name_____Grade_____

Parent's/Guardian's Name_____

Phone Number: home _____work _____

cell _____cell _____

Emergency contact: _____phone_____

Primary Physician: _____phone_____

Cardiologist_____phone_____

Cardiac Condition_____age at diagnosis_____

Brief description_____

Cardiac testing: **Stress Exercise Test date: _____Normal Abnormal Not done**
24 hour Holter Monitor date: _____ Normal Abnormal Not done
Echocardiogram date: _____ Normal Abnormal Not done

Most recent appointment with Cardiologist:_____ N/A

Open Heart Surgery: N/A_____Date:_____Procedure_____

Vital signs: Pulse_____(regular/irregular) Blood pressure:_____ Respirations:_____

Your child's signs and symptoms of cardiac episode are: (check all that apply)
___Chest tightness or pain ___ Shortness of breath or difficulty breathing ___ Tires easily
___Irritability ___Change in activity tolerance ___Paleness of skin ___Fainting or dizziness
___Blue or gray color around mouth, lips, or fingernails ___Other _____

How often does your child have symptoms? _____ last time?_____

Has your child ever been hospitalized? _____No _____ Yes If yes, when?_____

Please list the medications your child takes for his/her cardiac condition_____

_____

List any other medications taken on daily basis: _____

Does your child have any activity or dietary restrictions? ___ No ___Yes (Doctor's note required if activity is limited) Be specific:_____
Parameters acceptable for school attendance: Heart rate range:_____/minute_____

Blood pressure range:_____Respirations:_____

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

Call 9-1-1
Contact Parent/Guardian
Provide medication prescribed and available at school
Other: _____

Parent/Guardian Signature: _____ Date:_____

P. Rok 1/09