

# HERNANDO COUNTY SCHOOL DISTRICT

## Cardiac Care Plan

Students Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Student #: \_\_\_\_\_

Parent's/Guardian Name: \_\_\_\_\_ Phone Number: home - \_\_\_\_\_

Work - \_\_\_\_\_

Cell - \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: home - \_\_\_\_\_

Other - \_\_\_\_\_

Primary Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Cardiologist Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Cardiac Condition: \_\_\_\_\_ Age at diagnosis: \_\_\_\_\_

Brief Description: \_\_\_\_\_

Cardiac Testing: Test Date: _____	Stress Exercise Test:	Normal	Abnormal	Not Done
Test date: _____	24 hour Holter Monitor:	Normal	Abnormal	Not Done
Test date: _____	Echo Test:	Normal	Abnormal	Not Done

Most recent appointment with Cardiologist: \_\_\_\_\_ N/A

Open Heart Surgery: N/A \_\_\_\_\_ Date: \_\_\_\_\_ Procedure: \_\_\_\_\_

Vital signs: Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Pulse \_\_\_\_\_ (regular/irregular) Blood Pressure: \_\_\_\_\_

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 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.

\_\_\_\_\_ Not cleared for \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of physician (print/type): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Fl \_\_\_\_\_

Signature of physician: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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July 2006

Reorder from Printing