

CARDIAC CONDITION

Please provide the school a cardiac action plan initiated and signed by the physician

Student Name: _____ DOB: _____ Grade: _____

Parent / Guardian name and phone number: _____

With what type of cardiac condition has your student been diagnosed: _____

When was the student diagnosed: _____

Has the student been hospitalized because of their cardiac condition? ____ Yes; when? ____ No ____

Does the student wear an emergency medical bracelet / necklace? ____ Yes; which kind? ____ No ____

Does the student have an implanted defibrillator? ____ Yes; which kind? ____ No ____

Does the student have an implanted pacemaker? ____ Yes; which kind? ____ No ____

What symptoms does the student display when experiencing a cardiac emergency?

Can the student recognize their symptoms? ____ Yes ____ No

Please list any other chronic medical conditions: _____

Please list any other medications the student takes at home: _____

Please list any drug allergies: _____

Pediatrician and phone number: _____

Cardiologist and phone number: _____

Which hospital do you prefer if your student needs to be transported by emergency services: _____

Are you or someone familiar with your child able to accompany the student on field trips in case they have a cardiac emergency: ____ Yes ____ No

Please list any afterschool activities in which your student will participate during the school year:

Transportation:

Car Rider		Bus Rider	
____ AM	____ PM	____ AM bus #	____ PM bus #