Bus Route _____ School Year:_____-_____

Received date: _____

Cardiac Plan of Care

Student's Name: _____ DOB: _____ School: _____Grade: ____

1st Contact Name: _____ Phone: _____

2nd Contact Name: _____ Phone: _____

Medical/ Surgical History

Heart Condition/ Diagnosis: _____

Previous Surgeries: _____

Typical Symptoms for student: _____

Other Medical Diagnoses: _____

Symptoms Leading to Diagnosis/ Typical Symptoms for Student

Medications				
Medication	**Dosage**	**Route**	**Time Given**	**Given at School? (circle)**
				YES / NO
				YES / NO
				YES / NO
				YES / NO

Please note: for medications to be given at school, a Medication Administration Authorization (MAA) form must be completed, signed by both parent and physician and submitted to the school's office.

Pacemaker/ Implantable Cardiac Defibrillator (ICD)

☐ **Pacemaker**
Special Instructions: _____

☐ **Implantable Cardiac Defibrillator (ICD)**
Special Instructions: _____

Keep implantable devices at least 12 inches away from magnets, cell phones, or anti theft devices

Activity and Accommodations

X Student may rest as needed

☐ **Student may have water as needed**

☐ **Gym restrictions: _____**

☐ No contact sports ☐ No isometric activities (rope climbing, weight lifting, straining-no breath holding)

☐ **Recess restrictions: _____**

☐ **Outdoor temperature guidelines: do not go outside if temperature is above ____ or below ____**

☐ **Additional Accommodations:**

Emergency Response/ Treatment of Symptoms

****Cardiac symptoms can include: chest pain, heart palpitations, racing heart, dizziness, nausea, fear, panic, sweating, feet/ankle swelling, shortness of breath, abdominal bloating, fatigue, irritability, blue skin color, fainting, or sudden collapse.****

X Call parent for the following symptoms:

X Call 911 for the following symptoms:

***With any severe symptoms:**
1. Call for help (Have someone call the office/Activate MERT AND Call 911)
2. Start CPR if needed
3. Have someone get AED (automated external defibrillator)

Physician & Parent Signatures

Physician/Licensed Prescriber Name (Print):_____

Phone Number: _____ Fax Number: _____

Signature: _____ Date: _____

Parent/Guardian Signature: _____ **Date**: _____

CCS may need up to five (5) school days to comply with special accommodations requests. Parent and physician to determine if the child shall attend school during this time.

This POC is valid for one school year (August- June) and must be updated by a physician if any changes are made to the student's treatment. This plan will be shared with all appropriate school district staff