



## RE: Cardiac History; Individual Health Plan

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Grade: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

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**Brief Medical History** (Diagnosis, treatments, developmental delays, surgical procedures; what? when?):

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**Current Baseline Status :**

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- **My student no longer has challenges related to this cardiac history.**

Does the child exhibit any of the following symptoms presently?

- |   |   |
|---|---|
| <input type="checkbox"/> Chest pains  | <input type="checkbox"/> Shortness of breath while at rest                                    |
| <input type="checkbox"/> Slow weight gain   | <input type="checkbox"/> Shortness of breath during activities/ exercise                      |
| <input type="checkbox"/> Poor Appetite  | <input type="checkbox"/> Heart Arrhythmias (heart beat too fast/ too slow or irregular beats) |
| <input type="checkbox"/> Swelling   | <input type="checkbox"/> Heart murmur   |
| <input type="checkbox"/> Frequent Infections  | <input type="checkbox"/> Lightheadedness  |
| <input type="checkbox"/> Confusion  | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Nausea/ Vomiting   |   |
| <input type="checkbox"/> Cyanosis (bluish discoloration of the nail beds and/or around mouth) |   |

Current Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*Creswell School District medication form required for any medication to be given at school

Mobility/ Adaptive Needs:

- |  |  |
|--|--|
| <input type="checkbox"/> <b>None Needed</b>                        | <input type="checkbox"/> Class schedule adaptations    |
| <input type="checkbox"/> Wheelchair use                            | <input type="checkbox"/> Refer for special education - |
| <input type="checkbox"/> Transportation                            | OT, PT   |
| <input type="checkbox"/> Book Carrying                             | <input type="checkbox"/> Rest opportunities            |
| <input type="checkbox"/> Extra time for passing<br>between classes | <input type="checkbox"/> Adapted PE                    |

- **My student no longer has challenges related to this cardiac history.**

What activities are limited?

- |   |   |
|---|---|
| <input type="checkbox"/> <b>No Restrictions</b>     | <input type="checkbox"/> Running long distances/<br>periods Allowed |
| <input type="checkbox"/> No Contact Sports          | <input type="checkbox"/> No Running long distances/<br>periods      |
| <input type="checkbox"/> No competitive sports      |   |
| <input type="checkbox"/> Competitive Sports allowed |   |

Special procedures (needed at school; i.e. vitals signs, response to activities) : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dietary Restrictions/ Feeding Adaptations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Information, Comments, Instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Emergency Plan

IF YOU SEE ANY OF THESE	DO THIS
<ul style="list-style-type: none"> <li>● Change in activity tolerance</li> <li>● Respiratory distress</li> <li>● Cyanosis (bluish discoloration of the nail beds, around eyes and mouth)</li> <li>● Pain</li> <li>● Irritability</li> <li>● Malaise</li> <li>● Lethargy</li> <li>● Dizziness</li> <li>● Shortness of breath/Hiccoughs</li> <li>● Pulse is less than_____</li> <li>● No Breathing- No pulse</li> </ul>	<p>Start at top of list and work down stop at any point that is deemed appropriate by parent/guardian and/or School Nurse</p> <ol style="list-style-type: none"> <li>1. Allow student to rest</li> <li>2. Position student comfortably for easy breathing (sitting)</li> <li>3. If student responds to rest and sitting, allow quiet activities</li> <li>4. Notify School Nurse of situation (school nurse will notify parent)</li> <li>5. If student presents in severe distress: labored breathing, weakness, dizziness, or other- Call 911.</li> <li>6. If respiration cease, start rescue breathing</li> <li>7. If pulse ceases, start CPR</li> </ol> <p style="text-align: center;">CPR= CALL 911</p>
Other	
Other:	

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
School Nurse Name

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School Nurse Signature

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Date