

CLOVIS MUNICIPAL SCHOOLS CARDIAC ACTION PLAN

STUDENT NAME: _____ GRADE/CLASS: _____

We are providing you with this plan to help faculty and school nurses work with your child's physicians in controlling his/her cardiac condition at school. This plan will be kept in an accessible location at the school.

IN AN EMERGENCY, CONTACT:

Parent/Guardian: _____ Relationship: _____

Phone: (H) _____ (W) _____ (C) _____ (Pager) _____

Parent/Guardian: _____ Relationship: _____

Phone: (H) _____ (W) _____ (C) _____ (Pager) _____

Cardiac Doctor: _____ Phone: _____

Family Doctor: _____ Phone: _____

1. How old was this child when first diagnosed with cardiac condition? _____
2. When was he/she last seen by the Cardiac Doctor? _____
3. Has he/she ever had cardiac surgery? Yes No When? _____
Where? _____
4. Is this child currently taking medications for this cardiac condition? _____
Please list medications, time and dosage: _____

5. Child's usual cardiac symptoms? _____
6. When was the last time you had to call 911 or hospitalize for his/her cardiac condition? _____

7. Does he/she have any limited activities? Please check one category below.
___ Category I No restrictions. Activities may include endurance training, interscholastic athletic competition, contact sports.
___ Category II Moderate exercise. Activities include regular physical education classes, tennis, baseball.
___ Category III Light exercise. Activities include non-strenuous team games, recreational swimming, jogging, cycling, golf.
___ Category IV Moderate limitation. Activities include attending school, but no physical ed. Classes.
___ Category V Extreme limitation. Homebound or wheelchair.

Doctor Signature

Date

Parent Signature

Date