Cardiac

Washington County Department of Education
Coordinated School Health

University School
Phone: (423) 439-8674 Fax: (423)439-5921

Student:_____ DOB:_____ Teacher:_____ Grade:_____

1. Briefly describe the child's cardiac condition/diagnosis

_____
_____

2. Has surgery ever been required? _____Yes _____No If you answered yes, please describe:

_____
_____

3. Are medications required? _____Yes _____No (List below any medications needed)

MEDICATION	DOSAGE	TIMES OF ADMINISTRATION
_____	_____	_____
_____	_____	_____

The following symptoms may indicate a worsening of this child's cardiac disease:

_____ Decreased level of consciousness _____ Chest pain

_____ Clammy cool skin _____ Change in heartbeat

_____ Dizziness _____ Nausea

_____ Shortness of breath _____ Marked change in color: pale or blue

_____ Other (ex: parameters for heart rate or blood pressure) _____

EXERCISE AND SPORTS PARTICIPATION GUIDELINES

[ ] NO RESTRICTIONS- Included interscholastic athletics, contact sports
[ ] MODERATE EXERCISE- Includes physical education classes and recreational sports, but should avoid activities which require maximum or sustained effort
[ ] LIGHT EXERCISE- Included nonstrenuous recreational games such as swimming, jogging, bowling, (modified gym program without being graded recommended)
[ ] Must be permitted to determine his/her own level of activity and to stop and rest if needed.
[ ] NO PHYSICAL EDUCATION CLASSES

This Individualized Health Plan will be shared with trained personnel and Coordinated School Health Staff. It is the parent's responsibility to share this information with other staff you deem necessary (i.e. teachers, coaches, etc.). Your signature below indicates your understanding and agreement with this policy.

Physician Name: _____ _____ _____
Parent Signature Date

Office Number:_____

_____ _____ _____ _____
Physician Signature Date Parent Contact Phone