UNIVERSITY SCHOOL
EAST TENNESSEE STATE UNIVERSITY
68 Martha Culp Drive, Johnson City, TN 37614
Phone: (423) 439-8674 Fax: (423) 439-5921

Cardiac Individual Health Plan

Student: _____ DOB: _____ 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

The parent signature below gives permission for the school nurse or representative to fax this form to the indicated PCP and to communicate with said PCP, the PCP's office staff, and the ETSU University School faculty/staff regarding this health plan for the student named above, and their care. 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

PCP Phone & Fax number: _____

_____ _____
Physician Signature Date Parent Contact Phone