CARDIOVASCULAR MANAGEMENT PLAN
School Year: _____

Student Name:	**DOB:**
School:	**Student ID:**
CONTACTS:	
MOTHER:	**FATHER:**
HOME:	**HOME:**
WORK:	**WORK:**
CELL:	**CELL:**
If parents cannot be reached call:	
Name:	**Phone:**
Name:	**Phone:**
Physician:	**Phone:**
Hospital Preference:	

BASIC INFORMATION AND STUDENT HISTORY:

MEDICATIONS: (include name, dose and frequency of all meds)

1.

2.

3.

SYMPTOMS MAY INCLUDE:

☐ **shortness of breath**	☐ **chest pain/tightness**	☐ _____
☐ **gray/pale/sweaty skin**	☐ **fainting/dizziness**	☐ _____
☐ **rapid or irregular heart beat**	☐ **blue lips/fingertips**	☐ _____

MANAGEMENT: (i.e. adjustment in student's schedule; PE participation according to doctor's recommendation; oxygen or other medical treatments according to doctor's recommendation)

CALL PARENTS IF:

- symptoms interfere with ability to participate in class activities
- fever, nausea/vomiting, any signs of illness
- persistent pain
- other:

CALL 911 IF:

- student collapses
- change in level of consciousness
- sudden shortness of breath
- sweaty/ shock

Copy of this plan has been provided to Transportation Supervisor Yes □ No □

_____ _____

PARENT SIGNATURE DATE COUNTY SCHOOL NURSE SIGNATURE DATE

Confidentiality must be upheld when talking to other parents or outside persons. Information about students and family is strictly confidential.
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