CARDIOVASCULAR
Health Management Plan
SCHOOL YEAR: _____

STUDENT NAME:	**DOB:**
SCHOOL:	**STUDENT ID:**

MOTHER:	**FATHER:**
HOME:	**HOME:**
WORK:	**WORK:**
CELL:	**CELL:**
If parents cannot be reached call:	
Name:	**Phone:**
Physician:	**Phone:**
Cardiologist:	**Phone:** **Fax:**
Hospital Preference:	

CARDIAC DIAGNOSIS: _____DATE OF LAST CARDIOLOGY APPT: _____
Student History:

SURGICAL HISTORY:

MEDICATIONS (name, dose, frequency):

MANAGEMENT:
Activity: _____
Diet: _____
OTHER: _____
_____

CALL PARENT IF:
_____
_____

CALL 911 and HAVE SOMEONE GET THE AED IF STUDENT: (DO NOT LEAVE THE STUDENT)

1. Collapses/faints
2. Has a change in level of consciousness
3. Experiences shortness of breath
4. Is Sweaty/clammy
5. Other: _____

School Clinic: Copy of plan to be provided to Transportation Supervisor

_____ _____
PARENT SIGNATURE/DATE COUNTY SCHOOL NURSE SIGNATURE/DATE

Information about students and family is strictly confidential.