### Student Name:  
DOB:

<table>
<thead>
<tr>
<th>School:</th>
<th>Student ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOTHER:</td>
<td>FATHER:</td>
</tr>
<tr>
<td>HOME:</td>
<td>HOME:</td>
</tr>
<tr>
<td>WORK:</td>
<td>WORK:</td>
</tr>
<tr>
<td>CELL:</td>
<td>CELL:</td>
</tr>
</tbody>
</table>

If parents cannot be reached call:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Physician:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

Hospital Preference:

### BASIC INFORMATION AND STUDENT HISTORY:

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

1. 
2. 
3. 
4. 
5. 
6.

### SYMPTOMS MAY INCLUDE:

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

### MANAGEMENT:

- Activity Restrictions: (Note from Cardiologist)
- Diet:
- Other: (oxygen or other treatment recommended by physician)

### CALL PARENTS IF:

- shortness of breath
- chest pain/tightness
- extreme tiredness
- gray/pale/sweaty skin
- fainting/dizziness
- Other:
- rapid or irregular heart beat
- blue lips/fingertips
- Other:

### CALL 911 IF:

- student collapses
- sudden shortness of breath
- change in level of consciousness
- sweaty, clammy

**School Clinic: Copy of this plan should be provided to Transportation Supervisor**

<table>
<thead>
<tr>
<th>PARENT SIGNATURE</th>
<th>DATE</th>
<th>COUNTY SCHOOL NURSE SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
</table>

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

3/2016