# Medical Management Plan CARDIAC
## School Year 2024-2025

Student Name: _____ Date of Birth: _____

Physician's Name: _____ Phone #: _____

Address: _____ Fax #: _____

List Known ALLERGIES: _____

Brief description of condition: _____

Current Medications: _____

Name: _____ Dosage/Rout: _____ School ☐ Home ☐

Name: _____ Dosage/Rout _____ School ☐ Home ☐

Special Equipment: _____ School ☐ Home ☐

Symptoms child may demonstrate: Tires easily ☐ SOB ☐ Pain ☐ Other: _____

Vital Sign Parameters: B/P _____ Pulse _____ Respirations _____

Limitations: ☐ Cleared without limitations including all physical activities and recess.
☐ **Not Cleared** for (please be specific) _____

If student complains of chest pain, shortness of breath and/or has vital signs outside acceptable parameters, school personnel should immediately**:**

- **Call 9-1-1**
- **Contact Parent/Guardian**
- **Other:** _____

*Nursing services are recommended for the care of this student during the school day*

**Physicians Signature:** _____ **Date:** _____

**Continued Cardiac Plan for (Student NAME)** _____

| | | | | |
|---|---|---|---|---|
| Is your child compliant with their current treatment regime? | Yes | ☐ | No | ☐ |
| Does your child function independently with medication administration? | Yes | ☐ | No | ☐ |
| Are there any activity restrictions for your child? | Yes | ☐ | No | ☐ |

If yes, please list: _____

**PARENT to Complete: Authorization for Health Care Provider and School Nurse to Share Information**

I authorize my child's school nurse to assess my child as it relates to his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually. As the parent or guardian of the student named above, I request that the principal or principal's designee assist in the administration of medication/treatment prescribed for my child.

I understand that under provisions of Florida Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them. I authorize the physician to release information about this condition to school personnel.

| **Parent/Guardian Signature** | **Print Name** | **Date** |
|---|---|---|
| _____ | _____ | _____ |

Parent/Guardian: _____ Cell: _____

_____ Work _____

Parent/Guardian: _____ Cell: _____

_____ Work: _____