

Medical Management Plan

CARDIAC

School Year: _____

Student Name: _____ Date of Birth: _____

Physician's Name: _____ Phone #: _____

Address: _____ Fax #: _____

List Known ALLERGIES: _____

Brief description of condition: _____

Current Medications: _____			
Name: _____	Dosage/Rout: _____	School <input type="checkbox"/>	Home <input type="checkbox"/>
Name: _____	Dosage/Rout: _____	School <input type="checkbox"/>	Home <input type="checkbox"/>
Special Equipment: _____		School <input type="checkbox"/>	Home <input type="checkbox"/>

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	<input type="checkbox"/>	No	<input type="checkbox"/>
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Does your child function independently with medication administration?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Are there any activity restrictions for your child?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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If yes, please list: _____

PARENT/GUARDIAN 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 Statute 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administering 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
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Parent/Guardian: _____ Cell: _____

Work: _____

Parent/Guardian: _____ Cell: _____

Work: _____