SEEKONK PUBLIC SCHOOLS

Cardiac Care Plan

Student's Name_____**Grade**_____

Parent's/Guardian's Name_____

Phone Number: home _____**work** _____

cell _____**cell** _____

Emergency contact: _____**phone**_____

Primary Physician: _____**phone**_____

Cardiologist_____**phone**_____

Cardiac Condition_____**age at diagnosis**_____

Brief description_____

Cardiac testing: **Stress Exercise Test date:** _____**Normal Abnormal Not done**
24 hour Holter Monitor date: _____ **Normal Abnormal Not done**
Echocardiogram date: _____ **Normal Abnormal Not done**

Most recent appointment with Cardiologist:_____ **N/A**

Open Heart Surgery: N/A_____**Date:**_____**Procedure**_____

Vital signs: Pulse_____**(regular/irregular) Blood pressure:**_____ **Respirations:**_____

Your child's signs and symptoms of cardiac episode are: (check all that apply)
___Chest tightness or pain ___ Shortness of breath or difficulty breathing ___ Tires easily
___Irritability ___Change in activity tolerance ___Paleness of skin ___Fainting or dizziness
___Blue or gray color around mouth, lips, or fingernails ___Other _____

How often does your child have symptoms? _____ **last time?**_____

Has your child ever been hospitalized? _____No _____ Yes If yes, when?_____

Please list the medications your child takes for his/her cardiac condition_____

_____

List any other medications taken on daily basis: _____

Does your child have any activity or dietary restrictions? ___ No ___Yes
(Doctor's note required if activity is limited) Be specific:_____
Parameters acceptable for school attendance: Heart rate range:_____**/minute**_____

Blood pressure range:_____**Respirations:**_____

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

Call 9-1-1
Contact Parent/Guardian
Provide medication prescribed and available at school
Other: _____

Parent/Guardian Signature: _____ **Date:**_____

P. Rok 1/09