Medical Management Plan

CARDIAC

School Year 2016-2017

Student Name: ______________________ Date of Birth: ______________

Physician's Name: ______________________ Phone #: ______________

Address: ______________________ Fax #: ______________

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: ______________________