



Cardiac Individual Health Plan

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|--------------|---------|
| Student Name | DOB |
| School | Grade |
| School Year | Advisor |

MEDICAL INFORMATION

Please check the box that applies and enter information in Cardiac History below (transplant, surgery, congenital vs. acquired condition).

| | | | |
|--------------------|----------------------------------------------------------|----------------------------|----------------------------------------------------------|
| Cardiac Monitor | <input type="checkbox"/> Yes <input type="checkbox"/> No | Defibrillator or Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Current Medication | Rescue and Maintenance | | |

| | |
|---------------------------------------|--|
| Cardiac History | |
| PE - Activity Guidelines/Restrictions | |
| Special Precautions | |

EMERGENCY INTERVENTION

| Possible Symptoms Observed | Immediate Response |
|----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Chest Pain | Nursing Assessment (ABC's) Vital Signs |
| <input type="checkbox"/> Palpitations | |
| <input type="checkbox"/> Dizziness | |
| <input type="checkbox"/> Dysrhythmia | |
| <input type="checkbox"/> Sweating | |
| <input type="checkbox"/> Clubbing of fingers | |
| <input type="checkbox"/> Shortness of breath | |
| <input type="checkbox"/> Irritability | |
| <input type="checkbox"/> Rapid heart rate | |
| <input type="checkbox"/> Cyanosis | |
| <input type="checkbox"/> Fear and Panic | |
| <input type="checkbox"/> Fatigue | |

Depending on diagnosis, symptoms could be related to heart transplant rejections or cardiac medication levels rather than a congenital or acquired cardiac condition.

Because each student's needs are unique to their condition/diagnosis, the nurse must acquire directions from the student's licensed health care provider (LHP) in order to individualize the IHP.

| Severe Symptoms | Immediate Response |
|-----------------------------------------------------|-------------------------------------|
| Fainting or collapse with any known heart condition | Call 911 |
| Extreme chest pain | Notify Parent |
| Tachycardia that does not resolve | Notify School Nurse |
| Irregular heart rate | Notify School Principal |
| Difficulty breathing | Do not leave the student unattended |

Parent/Guardian Information

| | |
|-----------------|------------|
| Parent/Guardian | Home Phone |
| Work Phone | Cell Phone |
| Parent/Guardian | Home Phone |
| Work Phone | Cell Phone |

SIGNATURES

| | | |
|-----------------|--------------------------------------------|------|
| Parent/Guardian | <input type="checkbox"/> Signature on File | Date |
| School Nurse | <input type="checkbox"/> Signature on File | Date |
| Physician | <input type="checkbox"/> Signature on File | Date |

A copy of this plan will be kept in the school office and copies will be given to all appropriate staff.