CARDIAC - Emergency Care Plan

Student Name: _____

DOB: _____ Grade: _____

School: _____ Year: _____

Teacher: _____

Other ID: _____ Walker ☐ Bus Rider ☐ Bus Number: _____

Bus Driver: _____ Bus Route: _____

Parent/Guardian: _____ Guardian Phone: _____

Address: _____

Guardian 1: Wk Phone: _____ Cell Phone: _____

Guardian 2: Wk Phone: _____ Cell Phone: _____

Physician: _____ Phone: _____

Preferred Hospital: _____ Allergies: _____

Current Medications: _____ Rescue and Maintenance _____

Cardiac Monitor Yes ☐ No ☐ Please check the box that applies. (Please explain)

Defibrillator or Pacemaker Yes ☐ No ☐

HEALTH CONCERN: (Enter Cardiac Diagnosis)	
Describe Cardiac History below (transplant, surgery, congenital vs. acquired condition).	
PE/Activity Guidelines	
Special Precautions	

EMERGENCY INTERVENTION

Symptoms Observed	**Immediate Response**	TIME Initials
Possible Symptoms Chest pain — Palpitations Dizziness — Dysrhythmia Sweating — Clubbing of fingers Shortness of breath — Irritability Rapid heart rate — Cyanosis Fear and panic — Fatigue *Depending on diagnosis, symptoms could be related to heart transplant rejection 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 provide (LHP) in order to individualize the ECP. • Nursing Assessment (ABC's) Vital signs	
Fainting or collapse with any known heart condition **Extreme chest pain** **Tachycardia that does not resolve** **Irregular heart rate** **Difficulty breathing**	**Call 911** **Call Parents**	

Parent: _____ Date: _____

School Nurse LPN: _____ Date: _____

School Nurse RN: _____ Date: _____

A copy of this plan will be kept in the school office and copies will be given to:

☐ Para Pro ☐ Trans ☐ Teacher ☐ PE ☐ Student Services ☐ Health Room ☐ Other : ☐ Sec- Principal