HERNANDO COUNTY SCHOOL DISTRICT

Cardiac Care Plan

Students Name:_____**Date of Birth:**_____**Student #:**_____

Parent's/Guardian Name:_____**Phone Number: home -** _____
Work - _____
Cell - _____
Emergency Contact: _____**Phone Number: home -** _____
Other - _____

Primary Physician's Name:_____ **Phone Number:** _____
Cardiologist Name:_____ **Phone Number:** _____

Cardiac Condition:_____ **Age at diagnosis:** _____

Brief Description:_____
_____

Cardiac Testing: Test Date:_____ **Stress Exercise Test:** ○ **Normal** ○ **Abnormal** ○ **Not Done**
Test date:_____ **24 hour Holter Monitor:** ○ **Normal** ○ **Abnormal** ○ **Not Done**
Test date:_____ **Echo Test:** ○ **Normal** ○ **Abnormal** ○ **Not Done**

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

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

Vital signs: Ht. _____ **Wt.** _____ **Pulse**_____**(regular/irregular) Blood Pressure:** _____

Parameters acceptable for school attendance: **Heart rate range:** _____**/minute**

Blood pressure range:_____ **Respirations:** _____**/minute**

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

Call 911
Contact Parent/guardian
Provide medication prescribed and available at school
Other: _____

I hereby certify that an examination was performed by myself or an individual under my direct supervision with the following conclusion relating to school attendance and participation in extracurricular activities:

☐ **Cleared without limitation, including all physical activities and recess.**
☐ **Not cleared for** _____

Recommendations:_____
_____

Name of physician (print/type):_____
Address:_____ **City:**_____ **Fl** _____

Signature of physician:_____**Date:** _____

Parent's Signature: _____ **Date:** _____

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