Inspiring Excellence

LAKE STEVENS
School District

# Cardiac Care Plan/ 504 Plan

Student Picture

Student Name: ______________________________

DOB: ______________ Grade: __________

School: ______________ Year: __________

Teacher: ______________________________

__ 504 plan
__ IEP

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

Parent/Guardian: ______________________ Hm Phone: __________

Address: ______________________________

Guardian 1: Wk Phone: __________ Cell Phone: __________

Guardian 2: Wk Phone: __________ Cell Phone: __________

Physician: ______________________ Phone: __________

Preferred Hospital: ______________________ Allergies: __________

| **HEALTH CONCERN: (Enter diagnosis here) :** |
|---|
| Other pertinent information: |
| |
| |
| |

## EMERGENCY ASSESSMENT/ PLAN

**GOLDEN RULE:** IF found unconscious/ unresponsive, initiate CPR/ use Automated External Defibrillator (AED if available), and call 911

| **If you see the following:** | **What to do:** |
|---|---|
| Dizziness/ feeling faint | • Have student lie down and elevate legs<br>• Attempt to check heart rate __________<br>• If symptoms persist (still dizzy lying/ cannot sit up) – CALL 911<br>• If symptoms improve (no longer dizzy when sitting up) offer fluids and call parents |
| Palpitations (rapid/ irregular heart beat) | • Use calming approach<br>• Reassure student<br>• Attempt to check heart rate<br>• If symptoms persist (palpitations continue despite above) call 911<br>• If symptoms improve call parents |
| Chest pain | • Use calming approach<br>• Have patient lie down<br>• If severe and having dizziness or shortness of breath associated with chest pain, call 911<br>• If moderate and persists longer than 10 minutes, call 911<br>• Notify parents |
| Bleeding/ severe bruising (for patients on anticoagulant therapy | • Notify parents immediately<br>• If patient expericences injury to head/ abdomen, complaints of back/ belly pain, or coughing/ urinating/ vomiting blood: call 911<br>• For minor cuts/ light bleeding, provide basic first aid |

Parent: ______________________________ Date: __________

School Nurse RN: ______________________________ Date: __________

Inspiring Excellence
LAKE STEVENS
School District

# Cardiac Care Plan/ 504 Plan

Student Picture

| | | | |
|---|---|---|---|
| Student Name: | ______________________________ | | |
| DOB: | ______________________ | Grade: | __________ |
| School: | ______________________ | Year: | __________ |
| Teacher: | ______________________________ | | |

## Congenital Heart Defects

_____ Aortic stenosis
_____ Atrioventricular Septal Defect (AVSD/ AV canal)
_____ Double Inlet Left Ventricle
_____ Ebstein's Malformation
_____ Mitral Stenosis/ Insufficiency
_____ Pulmonary Atresia
_____ Tetralogy of Fallot (TOF)
_____ Transposition of the Great Arteries (TGA)
_____ Truncus Arteriosus
_____ Atrial Septal Defect (ASD)
_____ Total/ Partial Anomalous Pulmonary Venous Return (TAPVR/ PAPVR)
_____ Double Outlet Right Ventricle
_____ Hypoplastic Left Heart Syndrome (HLHS)
_____ Patent Ductus Arteriosus (PDA)
_____ Pulmonic Stenosis/ Insufficiency
_____ Coarctation or the Aorta
_____ Tricuspid Atresia
_____ Ventricular Septal Defect (VSD)

## Acquired Heart Conditions

_____ Cardiomyopathy
_____ Endocarditis
_____ Rheumatic Heart Disease
______ Congestive Heart Failure
______ Kawasaki's
______ Cardiac Transplant

## Abnormal Heart Rhythms

_____ Atrial Tachycardia
_____ Long QT Syndrome (LQTS)
_____ Supraventricular Tachycardia
_____ Other: _______________________
______ Atrial Flutter
______ Wolff- Parkinson- White Syndrome (WPW)
______ Ventricular Tachycardia (VT)

## Cardiac Devices

_____ Pacemaker
_____ Prosthetic Heart Valve (Aortic, Mitral)
_____ PDA Occlusion Device
_____ Implantable Cardiac Defibrillator (ICD)
_____ ASD/ VSD Occlusion Device
_____ Other: _______________________

| Date | Surgical/ Interventional Procedures |
|---|---|
| | |
| | |
| | |
| | |
| | |

Inspiring Excellence
LAKE STEVENS
School District

# Cardiac Care Plan/ 504 Plan

Student Picture

| | | | |
|---|---|---|---|
| Student Name: | | | |
| DOB: | | Grade: | |
| School: | | Year: | |
| Teacher: | | | |

Daily Medications:

| Cardiac Medications | Dose | Frequency | Common Side Effects |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Disaster Dosage (72 hour supply)- in case of disaster please administer:

| Cardiac Medications | Dose | Time | Common Side Effects |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| | | |
|---|---|---|
| LHP Signature: | Print name: | |
| Start date: | End date: (not to exceed current school year) | ☐ Last day of school<br>☐ Other: |
| Date: | Telephone: | Fax: |

**PARENT:**

- **I have reviewed the information on this School Cardiac Care Plan and Medication Orders and request/authorize trained school employees to provide this care and administer the medications in accordance with the Licensed Healthcare Provider's (LHP's) instructions.**
- **The plan must be updated each year and when there are major changes to the plan (such as in medication type or dose).**
- **All medication supplied must come in its originally provided container with instructions as noted above by the licensed health care provider.**
- **I authorize the exchange of medical information about my child's cardiac condition between the LHP office and school nurse.**

**The provider's office is encouraged to fax the plan to the student's school nurse. School nurse fax:** ____________________

- **A copy of "Notice of Parent/Guardian and Student Rights for Section 504" was given to parent/ guardian.** ☐ **yes**

**Parent/Guardian Signature** **Date**

Inspiring Excellence

LAKE STEVENS
School District

# Cardiac Care Plan/ 504 Plan

Student Picture

| | | | |
|---|---|---|---|
| Student Name: | | | |
| DOB: | | Grade: | |
| School: | | Year: | |
| Teacher: | | | |

**Staff who are involved with the student will be notified of the student's health condition and treatment guidelines.**
**A copy of "Notice or Parent/Guardian and Student Rights for Section 504" can be found at [www.lkstevens.wednet.edu/healthservices/forms.html](www.lkstevens.wednet.edu/healthservices/forms.html)**

## RECOMMENDATIONS FOR PHYSICAL ACTIVITY

The following recommendations are guidelines for physical activity for:

Patient Name: ________________________________________

Date of Exam: ________________________________________

| | ACTIVITY LEVEL | Initial |
|---|---|---|
| 1 | • May participate in the entire physical education program (PE class) without restriction, including all junior varsity (JV) and varsity competitive sports. | |
| 2 | • May participate in the entire PE program.<br>• May not participate in the JV/ varsity competitive sports where there is strenuous training and prolonged physical exertion (e.g. football, hockey, wrestling, lacrosse, soccer, basketball).<br>• Less strenuous sports such as baseball and golf are acceptable at the JV/ varsity level. | |
| 3 | • May participate in the PE class except for excessively stressful activities such as rope climbing, weight lifting, sustained running (e.g. laps) and fitness testing.<br>• Must be allowed to rest when tired.<br>• No JV/ varsity/ competitive sport participation. | |
| 4 | • May participate in mild PE class activities such as circle games, golf, and badminton<br>• No recreational, JV or varsity sports. | |
| 5 | • Restricted from entire PE class program and all recreational, JV, or varsity sports. | |

Duration of recommendations: ______________________________

Additional remarks:

**For District Nurse's Use Only**

| | |
|---|---|
| Medications received: | Amount received: |
| | |
| **School Nurse Signature** | **Date** |

Inspiring Excellence
LAKE STEVENS
School District

# Cardiac Care Plan/ 504 Plan

Student Picture

| | | | |
|---|---|---|---|
| Student Name: | ______________________ | | |
| DOB: | ______________ | Grade: | ________ |
| School: | ______________ | Year: | ________ |
| Teacher: | ______________________ | | |

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

Physician Signature: ______________________________ Date ____________

Physician Name: ____________________ Phone: __________ FAX: ____________