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| **Medical Management Plan** | **CARDIAC** |
| **School Year 2025-2026** |  |

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| Student Name: |  | Date of Birth: |  |
| Physician’s Name: |  | Phone #: |  |
| Address: |  | Fax #: |  |
| List Known ALLERGIES: |  |  |  |

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| --- | --- |
| Brief description of condition: |  |
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| Current Medications: |  |  |  |  |  |  |
| Name: |  | Dosage/Rout: |  | School |  | Home |  |  |
| Name: |  | Dosage/Rout |  | School |  | Home |  |  |
| Special Equipment: |  |  | School |  | Home |  |  |
|  |  |  |  |  |  |  |

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| Symptoms child may demonstrate: | Tires easily |  | SOB |  | Pain |  | Other: |  |

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| Vital Sign Parameters: | B/P |  | Pulse |  | Respirations |  |

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| Limitations: |  | Cleared without limitations including all physical activities and recess. |  |
|  |  | **Not Cleared** for (please be specific) |  |
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| 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:**
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| *Nursing services are recommended for the care of this student during the school day* |
| **Physicians Signature:** |  | **Date:** |  |

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| **Continued Cardiac Plan for (Student NAME)** |  |

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| 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: |  |  |  |  |  |

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| --- |
| **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: |  |