Student with Cardiac Condition at School – Short History

Student's Name: ____ Date: ___________________

Parent/Guardian Name: ____ Phone: __________________

Physician Advising Care of Cardiac Condition: ____
Physician's Phone: ________________

1. What is the name of the cardiac condition? ____

2. How long has your child had this condition? ____

3. What tests, procedures, surgery has your child needed for this condition: ______________________
   ____
   ____

4. What happens to your child when there is a problem with this condition? ______________________
   ____

5. What medications does your child take for this condition daily? _____________________________
   Does your child need to take medication at school? _______________________________________

6. What medication or treatment does your doctor recommend when there is a problem with this condition? ____
   ____

7. What kind of symptoms would your child have at school that you would consider an emergency?
   What do you want the school to do in a emergency? _______________________________________
   ____

8. Are there activities or circumstances that will likely cause a problem with this condition? __________
   ____
   ____

9. Are there restrictions on activities at school? Can your child participate in all school activities? _____
   ____

10. Is there any new information that you want to tell the school regarding your child's condition? ______
    ____
    ____

11. How do you want the school to treat a seizure if it should occur at school? ______________________
    ____

12. Comments:

Signature or Parent/Guardian: ______________________________ Date: __________