

# Medical Management Plan

## School Year 2023-2024

# CARDIAC

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

List Known ALLERGIES: \_\_\_\_\_

Brief description of condition: \_\_\_\_\_

Current Medications: _____			
Name: _____	Dosage/Rout: _____	School <input type="checkbox"/>	Home <input type="checkbox"/>
Name: _____	Dosage/Rout: _____	School <input type="checkbox"/>	Home <input type="checkbox"/>
Special Equipment: _____		School <input type="checkbox"/>	Home <input type="checkbox"/>

Symptoms child may demonstrate: Tires easily  SOB  Pain  Other: \_\_\_\_\_

Vital Sign Parameters: B/P \_\_\_\_\_ Pulse \_\_\_\_\_ Respirations \_\_\_\_\_

Limitations:  Cleared without limitations including all physical activities and recess.  
 **Not Cleared** for (please be specific) \_\_\_\_\_

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:** \_\_\_\_\_

*Nursing services are recommended for the care of this student during the school day*

**Physicians Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Continued Cardiac Plan for (Student NAME) \_\_\_\_\_**

Is your child compliant with their current treatment regime?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

Does your child function independently with medication administration?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

Are there any activity restrictions for your child?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

If yes, please list: \_\_\_\_\_

**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 Statute 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administering 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.

<b>Parent/Guardian Signature</b>	<b>Print Name</b>	<b>Date</b>
----------------------------------	-------------------	-------------

Parent/Guardian: \_\_\_\_\_ Cell: \_\_\_\_\_

\_\_\_\_\_ Work \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Cell: \_\_\_\_\_

\_\_\_\_\_ Work: \_\_\_\_\_