

Medical Management Plan School Year 2024-2025

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:** _____

