**CARDIAC INDIVIDUAL HEALTH PLAN (IHP)**

**\*\*THIS FORM IS VALID FOR SCHOOL DAY, EXTENDED DAY, OVERNIGHT AND WEEKEND FIELD TRIPS**

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

**□ STUDENT DOES NOT NEED A CARDIAC HEALTH PLAN AT THIS TIME (Physician signature required below)**

**----------------------THIS SECTION TO BE COMPLETED BY A LICENSED HEALTHCARE PROVIDER--------------------------**

|  |  |  |  |
| --- | --- | --- | --- |
| **CARDIAC DIAGNOSIS:** | | | |
| Does this student have any special internal or external equipment we need to consider in the school setting? If yes, please describe: | | | |
| **PE/ACTIVITY GUIDELINES:** Please check one of the following indicating any limitations to physical activities  **Category I, No restrictions:** Activities may include endurance training, interscholastic athletic competition, and contact sports.   * **Category II, Moderate exercise:** Activities include regular physical education classes, tennis, and baseball. * **Category III, Light exercise:** Activities include attending school, but no physical education classes. | | | |
| **Emergency Response:** Define a “cardiac emergency” for this student | | | |
| **SYMPTOMS OBSERVED** | | **IMMEDIATE RESPONSE, CHECK ALL THAT APPLY** | |
| Chest Pain | | Take vital signs Contact parent/guardian Call 911 | |
| Dizziness | | Take vital signs Contact parent/guardian Call 911 | |
| Sweating | | Take vital signs Contact parent/guardian Call 911 | |
| Shortness of breath (SOB) | | Take vital signs Contact parent/guardian Call 911 | |
| Rapid heart rate | | Take vital signs Contact parent/guardian Call 911 | |
| Lethargy | | Take vital signs Contact parent/guardian Call 911 | |
| Palpitations | | Take vital signs Contact parent/guardian Call 911 | |
| Dysrhythmia | | Take vital signs Contact parent/guardian Call 911 | |
| Activity intolerance | | Take vital signs Contact parent/guardian Call 911 | |
| Irritability | | Take vital signs Contact parent/guardian Call 911 | |
| Cyanosis | | Take vital signs Contact parent/guardian Call 911 | |
| Fainting or collapse | | Take vital signs Contact parent/guardian Call 911 | |
| Sudden, severe chest pain | | Take vital signs Contact parent/guardian Call 911 | |
| Tachycardia that does not resolve | | Take vital signs Contact parent/guardian Call 911 | |
| Irregular heart rate | | Take vital signs Contact parent/guardian Call 911 | |
| Sudden onset of severe SOB | | Take vital signs Contact parent/guardian Call 911 | |
| Loss of consciousness | | Take vital signs Contact parent/guardian Call 911 | |
| Licensed Healthcare Provider Signature: | **Date:** | **Printed Name:** | **Phone/Fax:** |

**---------------------------------THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN------------------------------------**

|  |  |  |  |
| --- | --- | --- | --- |
| Mother/Guardian: | | Father/Guardian: | |
| Cell: Work: Home: | | Cell: Work: Home: | |
| Parent/Guardian Signature: | Printed Name: | | Date: |

-------------------------------------------------------SCHOOL STAFF SECTION-----------------------------------------------------------

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| Form Received: \_\_\_\_\_\_\_\_\_ € Entered in Database € Exp. Date Checked Rvw’d by District RN: \_\_\_\_\_\_\_\_\_\_\_\_ |