

ST. JOHNS COUNTY SCHOOL DISTRICT
HEALTH SERVICES

CARDIAC MEDICAL MANAGEMENT PLAN
SCHOOL YEAR 2016-2017

Student Name: _____ Date of Birth: _____

Brief Description: _____

Current Medications:

Name: _____ Dosage: _____ School Home
Name: _____ Dosage: _____ School Home

Special Equipment: _____
School Home

Symptoms child may demonstrate: Tires easily Shortness of Breath Pain
 Other _____

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

Limitations: Cleared without limitation 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: _____

Name of physician: (print/type) _____

Signature of Physician: _____

Phone #: _____ Fax #: _____

Authorization for Health Care Provider and School Nurse to Share Information:

I authorize my child's school nurse to assess my child as regards 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 form child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

Parent/Guardian Signature

Print Name

Date

THIS SECTION FOR PARENT/GUARDIAN TO COMPLETE:

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

Date

Parent/Guardian: _____

Contact #'s:

Home _____

Work _____

Cell _____

Parent/Guardian: _____

Contact #'s:

Home _____

Work _____

Cell _____

Emergency Contact: _____

Contact #'s:

Home _____

Work _____

Cell _____