Medical Management Plan School Year 2023-2024

CARDIAC

Student Name: Physician's Name: Address:		Date of Birth: Phone #:				
				Fax #:		
		List Known ALLERGIES:				
Brief description of condition:						
Current Medications:						
Name:	Dosage/Rout:	:	School Home			
Name:	Dosage/Rout		School Home			
Special Equipment:			School Home			
Symptoms child may demonstrate: Tires easily	SOB	Pain Ot	her:			
Vital Sign Parameters: B/P	Pulse	F	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:	C	ate:

Continued Cardiac Plan for (Student NAME)

	_	 	
Is your child compliant with their current treatment regime?	Yes	No	
Does your child function independently with medication administration?	Yes	No	
Are there any activity restrictions for your child?	Yes	 No	
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 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	Print Name	Date
Parent/Guardian:	Cell:	
	Work	
Parent/Guardian:	Cell:	
	Work:	