ST. JOHNS COUNTY SCHOOL DISTRICT
HEALTH SERVICES

CARDIAC MEDICAL MANAGEMENT PLAN
SCHOOL YEAR _____

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 _____