

CARROLL COUNTY PUBLIC SCHOOLS

**SCHOOL HEALTH SERVICES  
CARDIAC PROCEDURE INFORMATION**

DATE: \_\_\_\_\_

To The Parent(s)/Guardian(s) of: \_\_\_\_\_

Grade: \_\_\_\_\_

You have indicated on the emergency procedure card that your child has a heart condition. In order for school personnel to respond to this quickly and effectively, additional information concerning this would be helpful. The information you supply will be kept confidential. **911 will be called in the event of an emergency.**

**Please answer the following:**

1. What is the diagnosis or name of the heart condition? \_\_\_\_\_
2. How old was your child when the diagnosis was first made? \_\_\_\_\_
3. Has your child been hospitalized or had heart surgery related to the heart condition?  
**No** \_\_\_ **Yes** \_\_\_ Date of Hospitalization(s) \_\_\_\_\_ Date of surgery \_\_\_\_\_
4. Does your child take medications for the heart condition? **No** \_\_\_ **Yes** \_\_\_  
Name of Medication \_\_\_\_\_ Dose \_\_\_\_\_ Time(s) \_\_\_\_\_ Will medication  
need to be taken in school? **No** \_\_\_ **Yes** \_\_\_ (Medication Order Needed)
5. Do you consider the heart condition serious or life threatening? **No** \_\_\_ **Yes** \_\_\_
6. How often/when does your child experience a problem as a result of the heart condition?  
\_\_\_\_\_

**What symptoms does your child experience?**

- a. Fainting
  - b. Cyanosis (blue skin color)
  - c. Chest pain
  - d. Confusion
  - e. Shortness of breath or trouble breathing
  - f. Unexplained sweating with cool skin
  - g. Heart rate (pulse) over \_\_\_\_\_ or heart rate (pulse) under \_\_\_\_\_
  - h. Other (specify) \_\_\_\_\_
  - i. Irregular heart rhythm or pulse
  - j. Dizziness
  - k. Pale skin color
  - l. Chronic fatigue
  - m. Palpitations
7. Please describe any actions that may assist your child with this problem while in school \_\_\_\_\_  
\_\_\_\_\_
  8. Please list any restrictions or limitations. \_\_\_\_\_  
\_\_\_\_\_
  9. Does your child need antibiotics for dental work? **No** \_\_\_ **Yes** \_\_\_  
Deep cuts? **No** \_\_\_ **Yes** \_\_\_, or minor surgery? **No** \_\_\_ **Yes** \_\_\_
  10. What is your child's normal blood pressure \_\_\_ / \_\_\_ pulse \_\_\_ respiratory rate \_\_\_
  11. Do you give permission for school personnel to contact the student's physicians? **Yes** \_\_\_ **No** \_\_\_

Pediatrician Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

12. Cardiologist Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

If you have any questions, please call me at \_\_\_\_\_. Thank you for your cooperation.

This information will be shared with those with a need to know.

Sincerely,