OPJH Clinic Fax – 904-278-2009

CLAY COUNTY SCHOOL DISTRICT
FLORIDA DEPARTMENT OF HEALTH - CLAY COUNTY
SCHOOL HEALTH SERVICES
2016-2017

CARDIAC MEDICAL MANAGEMENT PLAN

(Must be filled out completely by Physician/Healthcare Provider)

Student Name: ______________________________ DOB: ____________________

Parent / Guardian: ______________________________ Phone: ____________________

Physician / Provider: ______________________________ Phone: ____________________

Allergies: ____

Cardiac Diagnosis: ______________________________ **Surgeries**: ____________________

SYMPTOMS

Symptoms student may exhibit:
- ☐ Tires easily
- ☐ Shortness of breath
- ☐ Chest Pain
- ☐ Other (specify): ______________________________

MANAGEMENT

Medications at home: ☐ Yes (If yes, please specify): ______________________________
☐ No

Medications at School: ☐ Yes (If yes, please specify): ______________________________
☐ No

Special Equipment Needed at School: ☐ Yes (If yes, please specify): ______________________________
☐ No

Vital Signs at School:

Blood Pressure	☐ Yes	☐ No	Parameters: ______________________________
Pulse	☐ Yes	☐ No	Parameters: ______________________________
O_2 Sat	☐ Yes	☐ No	Parameters: ______________________________

(Schools do not have pulse oximeters. Parents must provide if student needs this type of monitoring.)

Limitations:
- ☐ Cleared without limitation including all PE, physical activity, and recess.
- ☐ **NOT CLEARED** for ______________________________

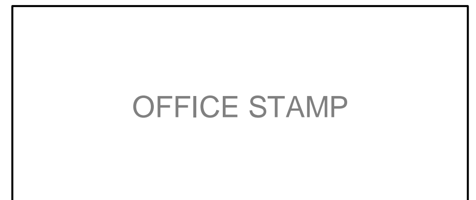
CARDIAC EMERGENCY PLAN

If student complains of chest pain, shortness of breath, or has vital signs outside acceptable parameters, School Personnel should immediately:
- ☐ **Call 911**
- ☐ Contact Parent/Guardian
- ☐ Other instructions (specify): ______________________________

______________________________ ____________________

Physician/Provider Signature (Required) **Date**

______________________________ ____________________



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School Nurse Signature **Date**