

# Cardiac Treatment Form

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Grade \_\_\_\_\_ School Year \_\_\_\_\_

School \_\_\_\_\_

1. Diagnosis: \_\_\_\_\_

Prior Surgeries: \_\_\_\_\_

2. Specify student participation levels in the following activities:

Yes       No Regular recess participation (walk, run, play at own pace).  
Comments:

Yes       No Participate in regular gym class  
Comments:

Yes       No Participate in competitive or contact sports  
Comments:

Yes       No Participate in timed run over a prescribed distance as tolerated  
Comments:

1. List any other precautions, restrictions or accommodations needed at school.

2. Current medications:

3. Describe potential emergency situations and recommended response/treatment at school.

*Possible Symptoms*

*Recommended Response/Treatment*

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**Unless otherwise specified, 911 will be called for:**

**\* Severe Chest Pain**

**\* Cyanosis/Skin Discoloration**

**\* Loss of Consciousness**

**\* Pale/Diaphoretic**

Emergency Contact Information:

Cardiologist: \_\_\_\_\_

Phone: \_\_\_\_\_

Father: \_\_\_\_\_

Phone: \_\_\_\_\_

Mother: \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date