CARDIOVASCULAR
HEALTH MANAGEMENT PLAN

STUDENT: **DOB:**
SCHOOL: **SCHOOL YEAR:**

CONTACTS:	
MOTHER:	FATHER:
HOME:	HOME:
WORK:	WORK:
CELL:	CELL:

EMERGENCY CONTACTS:
1.
2.

PHYSICIAN:	**PHONE:**
HOSPITAL PREFERENCE:	

BRIEF HISTORY:

ICD PLACEMENT:

Pacemaker Placement:

MEDICATIONS: (include name, dose and frequency of all meds)

1. 3.
2. 4.

SYMPTOMS MAY INCLUDE: Please Check Those That Apply:

__shortness of breath __chest pain/tightness
__gray/pale/sweaty __fainting/dizziness
__rapid or irregular heart beat __blue lips, fingertips

SCHOOL MANAGEMENT:
- adjust student's schedule as needed for energy conservation / safety
- PE participation according to doctor's recommendation
- Oxygen or other medical treatment according to doctor's recommendation

CALL PARENT IF:
- symptoms interfere with ability to participate in class activities
- fever
- persistent pain

CALL 911 IF:
- student collapses
- change in level of consciousness
- unmanageable pain
- sudden shortness of breath

TRANSPORTATION PLAN:
- Bus driver to receive a copy of the plan

Parent Signature Date Nurse Signature Date

Confidentiality must be upheld when talking to other parents or outside persons. Information about students and family is strictly confidential and all efforts to maintain this is very important. Revised 4/03

ARCHDIOCESE OF ATLANTA

MEDICATION PERMIT FORM

All medication should be given outside of school hours if possible. Three-times-a-day medications should be given before school, after school and at bedtime for optimal coverage. If necessary, medication can be given at school only under the following conditions:

1. If medication is needed in order for the student to remain in school, this form must be completed by the parent/guardian, signed by the physician, and returned with the medication to the school office or nurse.

2. All necessary medication prescribed for a student by a doctor or dentist must have this Medication Permit Form signed by the physician and parent. All prescription medication must be in the prescription bottle and labeled with a current pharmacy prescription label. "Over the counter" medication must be in original labeled container. Medications sent in baggies or unlabeled containers will not be given.

3. The **parent** is responsible to bring all medication to the clinic/office and to pick up unused medicine or it will be destroyed.

4. Experimental medication/dosages will not be given. Herbal medication, dietary supplements and other nutritional aids not approved as medication by the FDA, will not be administered at school.

5. Antibiotics will not be given at school by school personnel. If the parent feels the antibiotic must be given during the school day, the parent may come to the school office/clinic and administer it.

6. All medications must be kept in a locked cabinet/drawer in the school office/clinic and administered in the school office/clinic.

7. **High School** students whose doctor's written instructions require them to carry an inhaler on their person may do so. A second inhaler must also be kept in the clinic for use as needed. If a student allows another person to use the inhaler, the privilege of carrying one's inhaler may be revoked for both parties involved. Only those students in High School may transport their medication from home to the school office/clinic, and return unused medication home.

8. Only the **parent or adult designee** perform nebulizer treatments in school.

TO THE NURSE OR HEALTH REPRESENTATIVE OF: ST. PIUS X CATHOLIC HIGH SCHOOL

NAME OF STUDENT:_____ GRADE:____ ROOM:____

NAME OF MEDICATION:_____

DOSAGE AND DIRECTIONS FOR GIVING:_____

BEGINNING DATE:_____ ENDING DATE:_____

I hereby request that the medication specified above be given to the above named student, and that the medication may be given by someone other than a medically trained person.

I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Archdiocese of Atlanta, its servants, agents, and employees, including, but not limited to the parish, the school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Atlanta, its agents, servants, or employees, including, but not limited to the parish (if applicable), the school, the principal, and the individual giving or failing to give the medication.

SIGNATURE OF PARENT/GUARDIAN:_____ DATE:_____

SIGNATURE OF PHYSICIAN:_____ DATE:_____
(STAMPED SIGNATURE NOT ACCEPTED)

PHYSICIAN'S TELEPHONE NUMBER:_____