

**CLOVIS MUNICIPAL SCHOOLS  
CARDIAC ACTION PLAN**

This Action Plan is to be completed and signed by the child's parent/guardian and physician. The information on this plan is confidential. All staff that cares for your child will have access to this information in order to provide optimal safety in the school setting. Please contact the school at any time if you need to update this Action Plan.

Student Name \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Ph: (h) \_\_\_\_\_

Address \_\_\_\_\_ Ph: (w) \_\_\_\_\_ Ph: (c) \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Ph: (h) \_\_\_\_\_

Address \_\_\_\_\_ Ph: (w) \_\_\_\_\_ Ph: (c) \_\_\_\_\_

Emergency Phone Contact #1 \_\_\_\_\_

Name Relationship Phone #

Emergency Phone Contact #1 \_\_\_\_\_

Name Relationship Phone #

Physician Treating Student for Cardiac issues \_\_\_\_\_

Name Phone #

Other Physician \_\_\_\_\_

Name Phone #

**Cardiac Diagnosis** – please describe this student's Cardiac Diagnosis/Disability

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- Cardiac warning signs \_\_\_\_\_
- Cardiac symptoms \_\_\_\_\_
- Last Cardiac Event \_\_\_\_\_
- Cardiac surgeries \_\_\_\_\_

**Special Equipment/Activity restrictions**

- Does this student have any special internal or external equipment we need to consider in the school setting?  
 No  
 Yes – please describe \_\_\_\_\_
- Is student allowed to participate in physical education or other activities at school?  
 No – please explain/list limitations \_\_\_\_\_  
\_\_\_\_\_  
 Yes – may fully participate

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**Prevention Measures** – please list any **environmental control measures** or **dietary restrictions** the student requires to aid in preventing an asthma episode \_\_\_\_\_

\_\_\_\_\_

**Medications**

Daily Medication	Dosage, Route & Time of Day Given	Side Effects/Special Instructions

**Emergency Response**

A “cardiac emergency” for this student is defined as: \_\_\_\_\_

\_\_\_\_\_

**Cardiac Emergency Protocol** – (check all that apply and clarify below)

- Call 911**
- Contact school nurse at \_\_\_\_\_
- Notify parent or emergency contact
- Administer emergency medications as indicated below
- Other \_\_\_\_\_

**Emergency Medications**

Emergency Medication	Dosage & Route	Side Effects/Special Instructions

Other Instructions: \_\_\_\_\_

\_\_\_\_\_

I give permission for school personnel to release a copy of this Emergency Response Plan to emergency personnel in the event it is necessary to activate Emergency Medical Services and/or transport my child to the hospital.

**Parent Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Physician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_