***Student Health Services***

**Student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Type of cardiac condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mild  Moderate  Severe

Activity Restrictions:  YES  NO If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication needed at school:  YES  NO If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signs and Symptoms of Heart Problems:**

* Decreased Level of consciousness - Chest pain or pressure - Swelling abdomen, legs, feet
* Shortness of breath - Clammy, cool skin - Headache
* Fast, weak pulse - Sluggishness or unresponsiveness - Vomiting
* Fainting or dizziness - Numbness or tingling - Poor appetite
* Rapid, slow, irregular heart beat - Pale or bluish skin color - Trembling, seizures
* Alteration in speech, vision, hearing - Problems with coordination or balance

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| --- | --- |
| **If this happens:**  | **Do this:** |
| Student experiences any of the above symptoms but is:* Conscious
* Alert
* In no apparent urgent distress
 | 1. Notify the school nurse
2. Assist the student to comfortable seated or lying position
3. Have student take slow deep breaths and relax as much as possible
4. Once student has stabilized, **escort** to the school nurse. The student should not be sent anywhere alone when having symptoms.
5. Call Parent/guardian
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| Student experiences any of the following:* Unconscious
* Unresponsive
* Faints
* Pulse is abnormal (too fast or too slow)
* Difficulty breathing that does not improve with rest
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 1. Call 911 immediately
2. Send someone to retrieve the AED immediately and bring to scene
3. AED location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Call for school nurse and nearest CPR/AED trained staff
5. Front office to notify parent/guardian
6. Office staff to wait in front to meet EMS and escort to correct location
7. School employees to send all students into hallway or nearby classroom
8. Monitor airway, breathing, circulation
9. Administer CPR, if necessary, until AED is brought to scene
10. When AED available, start AED, apply pads, and follow AED prompts.
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 Parent/Guardian Signature Phone# Date

***Emergency Contact in the event parent cannot be reached:*** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**FOR SCHOOL USE ONLY**

School Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

** Plan reviewed with \_\_\_\_\_\_\_\_\_\_\_\_\_, teachers \_\_\_\_\_\_\_\_\_,TA \_\_\_\_\_\_\_\_, bus driver\_\_\_\_\_\_\_ Special area teachers, \_\_\_\_\_\_\_\_\_\_\_\_\_ First Responders**

**Parental Permission and Release of Medical Information:**

* As parent/guardian of above student, I consent for the employees of Huntingdon Area School District to follow the plan and use the designated medications on my child in accordance with the instructions above.
* I understand that I am to provide the school with medication and signed authorization form, supplies, etc. to follow the plan.
* I understand that this plan will be shared to all those who need to know (all student’s teachers/office personnel/ bus driver/ emergency responder, etc) unless written objection is stated on this form
* I hereby acknowledge that I have read, understand, and support the Emergency Health Plan.

**Release of Medical Information**

* I hereby authorize my child’s health care provider to release to the school nurse, principal, or other authorized school personnel, specific confidential medical information contained in my child’s record regarding his/her medical condition. Only school staff delivering health care services to my child in school will use this information.

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 Parent/Signature Date