Alamogordo Public Schools
Health Services
Cardiac Action Plan

Name:	**DOB:**
Parent/Guardian:	**Phone #'s:**
Physician Name:	**Physician #**

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. Physician Signature Required

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_____

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

_____

• Cardiac warning signs _____

• Cardiac symptoms _____

• Last Cardiac Event _____

• Cardiac surgeries _____

Special Equipment

• Does this student have any special internal or external equipment we need to consider in the school setting?

˜ No

˜ Yes – please describe _____

Exercise Recommendations

Please check those recommendations which apply:

- ☐ Full activities, may participate in competitive sports, no restrictions
- ☐ Full activities, may participate in competitive sports except contact sports (football, basketball, soccer, boxing, etc.)
- ☐ Full activities, may participate in competitive sports except wrestling, power weight lifting and isometric sports.
- ☐ Full activities, but no competitive sports
- ☐ Full activities, including physical education class, allowed to rest if become tired, no competitive sports.
- ☐ Modified physical education class; limit running, jumping and aerobic exercise to patient's toleration; allow to rest, when/if necessary
- ☐ Modified physical education class; limited to the maximal exertion of a brisk walk or less.
- ☐ Modified physical education class; limited to walking or helping the instructor
  Level of supervision should be _____
- ☐ Other parameters to observe (for example: oxygen saturation, BP, HR)
  _____
- ☐ No physical education class until _____ or further notice

Dietary Restrictions:

_____

Medications	Dosage, Route and Time to be given	Side Effects/Special instructions

Parent Signature_____ **Date**_____

School RN Signature_____ **Date**_____

Physician Signature _____ **Date**_____

Nursing Diagnoses: Alteration in Activity Tolerance(NANDA 6.1.1.2) Alteration for Cardiac Output (NANDA 1.4.2.1)