Lawrence County School System Health Services
Cardiac Action Plan
This portion is completed by the Physician/Healthcare Provider and when signed may serve as treatment and medication authorization.

Student's Name: _____ DOB: _____

Student Diagnosis: _____

Cardiac Action Plan:

1. The following symptoms may indicate a worsening of this student's cardiac condition: (Check all symptom(s) that apply)
   - ☐ Decreased level of consciousness
   - ☐ Clammy, cool skin
   - ☐ Dizziness
   - ☐ Shortness of breath
   - ☐ Marked change in color: pale or blue
   - ☐ Other: _____

2. Medication Orders/Treatment during School Hours: _____

   Possible Side Effects: _____ Duration of Treatment: _____

Steps to follow for a Cardiac Event are:

1. **Check for responsiveness and breathing.**
2. **If not responsive and not breathing, begin CPR.**
3. **Delegate call to 911**
4. **Delegate call to parent/guardian.**

** It is the parent's responsibility to determine follow-up care for symptoms. **

EXERCISE AND SPORTS PARTICIPATION GUIDELINES:

Student may participate in physical activities as below:

☐ NO RESTRICTIONS (includes interscholastic athletics, contact sports)

☐ LIMITED PARTICIPATION in activities checked below:

O MODERATE EXERCISE ONLY (includes PE classes and recreational sports but should avoid activities which require maximum or sustained effort).

O LIGHT EXERCISE ONLY (includes nonstrenuous recreational games such as swimming, jogging, bowling, golf, riflery; modified gym program without being graded recommended)

O SELF-LIMITING - Must be permitted to determine his/her own level of activity and to stop and rest if needed.

☐ NO PHYSICAL EDUCATION (PE) CLASSES

Physician Name: _____ Phone: _____

Physician Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

This is the Medication Authorization form when signed by a healthcare provider. *Rev 2020*