Belton ISD Health Services
Parental Authorization for Cardiac Emergency Plan
School Year: 2019-2020 Campus:

Student Last Name	**Student First Name**	DOB	Grade/Homeroom	Transportation: ○ Rides bus #_____ ○ Car rider ○ Walker

○ No ○ Yes Student in Special Education Program? ○ No ○ Yes Student in 504 Program? (School accommodations for those with chronic health conditions)		
Diagnosis/Significant medical history		
Current meds to treat cardiac condition	Date of last hospitalization	Physical Restrictions: ☐ No ☐ Yes (explain):
Cardiac Emergency Medication needed at school: Dosage/Route/Times		Expiration Date
Medication at school: ☐ N/A ☐ In Health Office		

Standard Cardiac Emergency Plan for School
Please review standard cardiac emergency plan for school and add additional instructions as needed

☐☐If You See Any Of These:	**Do this:**
• Verbalizes "Feels like heart is beating too fast" • Short of Breath • Changes in Color around mouth or lips or nail beds • Dizziness • Other signs/symptoms:	• Stop activity • **Student may need rescue/prescribed medication • Call the nurse/ office for assistance: check pulse, respirations, O2Saturation, and level of consciousness. • Place student in comfortable position • Stay with student- **DO NOT LEAVE ALONE**
Severe Symptoms **If You See Any Of These:** • Decreased level of consciousness • A marked change in color: pale or blue • Chest pain • Absent pulse or respirations	**Do This:** • Call or have someone **CALL 911** • Call the nurse/office for assistance • Start CPR if indicated **CONTACT PARENT AS SOON AS POSSIBLE**

Additional instructions/safety measures:

Physician: Print Name	Physician Signature	Physician Phone	Date

I grant permission to BELTON ISD to follow the above plan for my child. I am giving permission to BISD staff to contact my physician for additional information if necessary. If the school nurse deems it necessary, I grant permission to notify my child's teacher(s) of his health condition. I understand that a medically untrained designee of the principal may carry out the plan and/or administer any prescribed medication.

Parental Signature	Best emergency phone	Other phone	Date
Emergency Contact	Best emergency phone	Other phone	

Trained Staff-Print name and initial after completing training on administering this medication, which includes seeking additional training or assistance as needed when administering this medication. **Trainer-** sign and date beside name of staff member that has completed the knowledge and skills to administer this medication.

Trained staff: Print Name/initial	**Trainer Signature**	**Training Date**	**Trained staff: Print Name/initial**	**Trainer Signature**	**Training Date**

If administered:	**Date**	**Time**	**Initials**	**Date**	**Time**	**Initials**