FLORIDA DEPARTMENT OF HEALTH IN MIAMI-DADE COUNTY
SCHOOL HEALTH PROGRAM
HEALTH HISTORY AND CONSENT - CARDIAC CONDITION

Student: _____ **DOB**_____ **Teacher:** _____ **Grade:** _____
School: _____**Parent/Guardian & Phone(s):** _____
Physician & Phone: _____ **School Year:** _____
KNOWN ALLERGIES: _____

Dear Parent/Guardian:
School records or medical information indicates your child has a cardiac condition. In order to attend to your child's health and safety, the school requires a health history. Please return this form to the nurse as soon as possible. It will become part of your child's confidential school health record. Our primary concern is that your child's healthcare needs are met while in school.

_____ _____ _____
School Nurse Phone number Date

1. What type of cardiac condition does your child have? (☑ **all that apply**)
   ☐ Aortic stenosis ☐ Coarctation of the aorta ☐ Congestive heart failure ☐ Hypertension ☐ Murmur ☐ Septal defect
   ☐ Patent ductus arteriosis ☐ Rheumatic heart disease ☐ Tetralogy of fallot ☐Transposition of the great arteries
   ☐ Cardiac Surgery – Type_____ When? _____
   ☐Other (Specify) _____
2. Your child's signs and symptoms of a cardiac episode are: (☑ **all that apply**)
   ☐ Chest tightness or pain ☐ Shortness of breath or difficulty breathing ☐Tires easily ☐ Irritability
   ☐ Paleness of skin ☐ Fainting or dizziness ☐ Blue or gray color around mouth, lips, or fingernails
   ☐ Other _____
3. How often does your child have symptoms? _____
   When was the last time? (Month/Year) _____
4. Has your child ever been hospitalized? ☐ No ☐ Yes if yes, when: (Month/Year) _____
5. Please list the medications your child takes for his/her cardiac condition daily:
   Name of Medication Dosage Time
   _____
6. Does your child take any **other** medications?
   Name of Medication Dosage Time
   _____
7. List any side effects your child experiences from the above medication(s)? _____
8. Does your child have any activity or dietary restrictions? ☐ No ☐ Yes **(Doctor's letter is required if activity is limited)**
   Be specific: _____
9. Self Care (Please circle responses)
   a. Is your student able to monitor their symptoms and report changes? No Yes
   b. Does your student:
      1. Know what medication to take No Yes
      2. Know what activity/dietary limitations No Yes
      3. Tell an adult immediately, if not feeling well No Yes
      4. Wear a medical alert bracelet, necklace, or watchband No Yes

CONSENT

Please circle your response and sign:**(I do /I do not) give the School Nurse my permission to share information relevant to my child's medical status with school staff on a "need to know" basis, if she/he determines that this information is necessary to assure my child's health and safety.**

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____