



**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 _____
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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 arteriosus Rheumatic heart disease Tetralogy of fallot
 - Transposition of the great arteries Cardiac Surgery: _____
 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 (**Healthcare provider 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: _____