WATCHUNG HILLS
REGIONAL HIGH SCHOOL

ELIZABETH C. JEWETT, PHD
SUPERINTENDENT

TIMOTHY M. STYS, CPA
BUSINESS ADMINISTRATOR

WILLIAM J. LIBRERA
PRINCIPAL

Dear Parent/Guardian,

You have indicated in school records that your child has an ongoing health need that may require medication and/or treatment during the school day. Please see your physician to have the appropriate action plan completed and signed and submit it to the health office prior to the first day of school.

New Jersey State Law requires your healthcare provider's written order and parent/guardian authorization for a nurse to administer medications. Medications must be in pharmacy –prepared containers and labeled with the name of the student, name of the drug, strength, dosage, frequency, name of physician, date of original prescription. In the event of an emergency other staff may need to care for your child until medical personnel arrives. Please read and sign below if you agree to share medical information with WHRHS staff for your child.

I give permission to the school nurse, trained personnel, and other designated staff members of Watchung Hills Regional High School to perform and carry out the necessary care tasks as outlined by N.J.S.A 18A:40-12.11-21, referring to the administration of Glucagon, and N.J.S.A.18A:40-12.5 for the administration of epinephrine via a pre-filled auto-injector mechanism. I also consent to the release of information contained in this Medical Management Plan to all staff members and other adults who have custodial care of my child during the school day and during school sponsored events who may need to know this information to maintain my child's health and safety.

Please send/bring completed forms and any medications or equipment to the Health office prior to or on the first day of school. This information enables the healthcare team at WHRHS to provide optimal care to your child in the event of an emergency. Your immediate attention to these matters is greatly appreciated. If you have any further questions please do not hesitate to contact the nurses at 908-647-4800.
Thank You

The School Nurses

Acknowledged and Received by:

_____
Student's Parent/Guardian

Date _____

Cardiac Care Plan

Student Name_____ Grade_____

Parent/Guardian:_____Hm Phone: _____
Address: _____
Guardian 1: Wk Phone:_____ Cell Phone: _____
Guardian 2: Wk Phone:_____ Cell Phone: _____
Physician: _____Phone:_____
Preferred Hospital:_____Allergies: _____

HEALTH CONCERN: (Enter diagnosis here) :

Other pertinent information:

EMERGENCY ASSESSMENT/ PLAN

GOLDEN RULE: IF found unconscious/ unresponsive, initiate CPR/ use Automated External Defibrillator (AED if available), and call 911

If you see the following:	What to do:
Dizziness/ feeling faint	• Have student lie down and elevate legs • Attempt to check heart rate _____ • If symptoms persist (still dizzy lying/ cannot sit up) – CALL 911 • If symptoms improve (no longer dizzy when sitting up) offer fluids and call parents
Palpitations (rapid/ irregular heart beat)	• Use calming approach • Reassure student • Attempt to check heart rate • If symptoms persist (palpitations continue despite above) call 911 • If symptoms improve call parents
Chest pain	• Use calming approach • Have patient lie down • If severe and having dizziness or shortness of breath associated with chest pain, call 911 • If moderate and persists longer than 10 minutes, call 911 • Notify parents
Bleeding/ severe bruising (for patients on anticoagulant therapy	• Notify parents immediately • If patient experiences injury to head/ abdomen, complaints of back/ belly pain, or coughing/ urinating/ vomiting blood: call 911 • For minor cuts/ light bleeding, provide basic first aid

Parent: _____ Date: _____

School Nurse: _____ Date:

Congenital Heart Defects

____ Aortic stenosis

____ Atrial Septal Defect (ASD)

____ Atrioventricular Septal Defect (AVSD/ AV canal)

____Total/ Partial Anomalous Pulmonary Venous Return (TAPVR/ PAPVR)

____ Double Inlet Left Ventricle

____Double Outlet Right Ventricle

____ Ebstein's Malformation

____Hypoplastic Left Heart Syndrome (HLHS)

____ Mitral Stenosis/ Insufficiency

____Patent Ductus Arteriosus (PDA)

____ Pulmonary Atresia

____Pulmonic Stenosis/ Insufficiency

____ Tetralogy of Fallot (TOF)

____Coarctation or the Aorta

____ Transposition of the Great Arteries (TGA)

____Tricuspid Atresia

____ Truncus Arteriosus

____Ventricular Septal Defect (VSD)

Acquired Heart Conditions

____ Cardiomyopathy

_____Congestive Heart Failure

____ Endocarditis

_____Kawasaki's

____ Rheumatic Heart Disease

_____Cardiac Transplant

Abnormal Heart Rhythms

____ Atrial Tachycardia

_____Atrial Flutter

____ Long QT Syndrome (LQTS)

_____Wolff- Parkinson- White Syndrome (WPW)

____ Supraventricular Tachycardia

_____Ventricular Tachycardia (VT)

____ Other: _____

Cardiac Devices

____ Pacemaker

____Implantable Cardiac Defibrillator (ICD)

____ Prosthetic Heart Valve (Aortic, Mitral)

____ASD/ VSD Occlusion Device

____ PDA Occlusion Device

____Other: _____

Date	Surgical/ Interventional Procedures

Daily Medications:

Cardiac Medications	Dose	Frequency	Common Side Effects

HCP Signature:		Print name:
Start date:	End date: (not to exceed current school year)	☐ Last day of school ☐ Other:
Date:	Telephone:	Fax:

PARENT:

- **I have reviewed the information on this School Cardiac Care Plan and Medication Orders and request/authorize trained school employees to provide this care and administer the medications in accordance with the Healthcare Provider's (HCP's) instructions.**
- **The plan must be updated each year and when there are major changes to the plan (such as in medication type or dose).**
- **All medication supplied must come in its originally provided container with instructions as noted above by the health care provider.**
- **I authorize the exchange of medical information about my child's cardiac condition between the HCP office and school nurse. The provider's can fax plan directly to Health Office (secure fax line) 908-647-4828**

Parent/Guardian Signature **Date**

RECOMMENDATIONS FOR PHYSICAL ACTIVITY

The following recommendations are guidelines for physical activity for:

___May participate in Physical Education and Sports without restriction.

___May not participate in Physical Education and Sports.

Duration of recommendations:_____

Additional recommendations/ accommodations:

_____

_____

_____

Physician Signature: _____ Date _

Physician Name: _____ Phone: _____ FAX: _