DIXON MONTESSORI CHARTER SCHOOL
Cardiac Action Plan (2020/2021 School Year)
355 N. Almond St. • Dixon, CA 95620
Tel: (707) 678-8953 • Fax: (707) 676-5215
www.dixonmontessori.org

Name: _____D.O.B.:_____Grade/Teacher:_____
Parent/Guardian: _____ Phone:_____
Parent/Guardian: _____ Phone:_____
Diagnosis/Significant Medical History: _____
_____
Allergies: _____
Current **Medications** to treat cardiac condition: _____
Keep in Nurses Office? __Yes __No
Date of last hospitalization: _____
Treatments/Procedures/Devices: ___ Oxygen ___Other: _____
Specific Activity Limitations or Restrictions: Yes/No (explain):
PE/Outdoor Activity/Recess: _____
Athletics/Extra-Curricular: _____
Other: _____
Does Student Need:
Medication at School? __Yes __No
Vital Signs Monitoring? __Yes __No
Fluid Management Assistance? __Yes __No
Infection Protection Instruction? __Yes __No
If you answered yes to any of the above, please provide detail, i.e. vital signs parameters:
_____
_____

Standard Cardiac/CV Emergency Plan For School-Please review and make changes/additions as needed.

Minor Symptoms: **If You See Any of These:** • Verbalizes "Feels like heart is beating too fast" • Shortness of breath • Changes in color around mouth or lips or nail beds • Dizziness • Other signs/symptoms	**Do This:** • Stop Activity • **Student may need rescue/prescribed medication • Call the Nurse/Office for assistance: Check Pulse, Respirations, Saturation, and level of consciousness • Play student in a comfortable position • Stay with the 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 **SIGNS/SYMPTOMS ABOVE MAY INDICATE BLEEDINGS AND SHOULD NOT BE TAKEN LIGHTLY**	**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:
_____
_____

I grant permission to Dixon Montessori Charter School to follow the above plan for my child. I am giving permission to DMCS to contact my physician for additional information as necessary. If the school nurse deems necessary, I grant permission to notify my student's teacher of his/her health plan.

Physician-Print Name:	Physician Phone:
Parent/Guardian Signature:	Parent/Guardian Phone:

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