Houston County Board of Education

Health Related Services

CARDIAC QUESTIONNAIRE

Student: _____ **DOB**: _____ **Valid for school year:** _____

Please complete this form for your student's cardiac needs so staff can plan effectively for their care while at school.
Please note: If your student is participating in activities before and after the school day including: after school care, extracurricular activities/trips, athletics, or camps, it is imperative that YOU inform the supervising adults of this students medical needs. This is necessary because the school may not be aware of all activities the student is participating in beyond the normal school day/year.

1. What type of cardiac condition does your student 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
   □Surgery – Type_____When _____
   □Other (Specify) _____

2. What are your student's usual signs and symptoms of a cardiac episode? (☑ **all that apply**)
   □ Chest tightness or pain □Shortness of breath or difficulty breathing □Tires easily □Irritability □Paleness of skin
   □Change in activity tolerance □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? _____
   Does there seem to be a trigger to your student's cardiac episodes?_____

4. Has your student ever been hospitalized other than for cardiac surgery listed above? □ No □Yes If yes, explain.
   _____

5. Please list the medications your child takes:

	MEDICATION	AMOUNT TAKEN	HOW OFTEN AND FOR WHAT SIGNS?
1.	_____	_____	_____
2.	_____	_____	_____
3	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

6. Does your student have any activity restrictions? □ No □ Yes **(Doctor's letter is required for specific directions)**
7. Does your student have any dietary restrictions? □ No □ Yes **(Meal Modification form will be needed, HRS20)**
8. Dr. _____ is currently treating cardic condition. Phone number:_____

Please sign to give consent for the exchange of medical information with the above physician and the school.
Signature: _____Relationship:_____

If medications must be given during school hours, an **Authorization for Medication** HRS29 form must be completed every school year. It must be filled out and signed by you and your physician. Medications used in school must be in the original container. When you have a prescription filled, ask the pharmacist for two containers; one for school and one for home use. If your student participates in field trips and needs medication during that time, a separate container may be necessary for that day as well.

Revised 5/2016