Heart Condition Documentation

Completed by Health Care Provider

Student Photo

Name	Birth Date:

Diagnosis:_____

Brief description of condition:_____

_____

How would this current condition adversely affect student's educational performance?_____

_____

Medication and dosage:_____

_____

Possible side effects of medication that school personnel need to be aware of:_____

_____

Comments:_____

_____

Student cleared for activity without restrictions? ☐ Yes ☐ No*

Specify Restrictions:_____

_____

(*will need Health Care Provider clearance to remove restrictions)

Cardiac Symptoms:

- **Mental:** Feels "scared"; something bad is going to happen
- **Respiratory:** Short of breath/difficulty breathing
- **Skin:** gray/blue color, sweating, clammy
- **Heart:** Chest pain Irregular pulse rapid pulse fainting

Action Plan: If sending student with cardiac symptoms anywhere, send with an escort

Call 911 if:	**Then do:**
• Sudden severe chest pain • Sudden onset of severe shortness of breath • Loss of consciousness • Other:	• Stay with student • Begin CPR if the need arises • Have another school employee contact parents • Other:
Further recommendations from HCP: ***(classroom, school bus, field trips, disaster, Weight limits, PE restrictions, etc.)***	

Health Care Provider Signature:	Date:
Health Care Provider name (print or type)	
Phone:	Fax:
School Nurse Signature:	Date:

Date Reviewed with Parent (To be updated at least every 3 years)

Date/Nurse Signature	Date/Nurse Signature	Date/Nurse Signature

AUTHORIZATION FOR MUTUAL RELEASE OF RECORDS

Kennewick School District Nursing Services

Purpose: *As a parent, guardian or student, you have the right to give permission or not give permission for the release of your child's records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the Family Education Right and Privacy Act. FERPA, (for example, transfer of records from one school district to another).*

Student Name: _____ Date: _____ DOB: _____

I hereby authorize the release of records

From:		***To:***	
Agency/Person:		**Agency/Person:** ***KSD Nurse***	
Street Address:		**Street Address:**	
City, State, Zip:		**City, State, Zip:** ***Kennewick, WA,***	
Tel:	***Fax:***	***Tel: 509-222-***	***Fax: 509-222-***

Describe the records to be disclosed: _Diagnoses, medication and any medical recommendations that are applicable for the student at school._

The reason for disclosing the record(s) is: To provide safe care of the student in the educational setting.

I understand that this information obtained will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards by a school district and not the Health Insurance Portability and Accountability Act (HIPAA).

This authorization is valid from _____/_____/_____ **to** _____/_____/_____**.**

I understand that my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

_____

Parent/guardian/student signature Date