**BRADFORD COUNTY DISTRICT SCHOOLS and**
**BRADFORD COUNTY HEALTH DEPARTMENT**
**SCHOOL HEALTH SERVICES**

# CARDIAC CONDITION QUESTIONNAIRE/HISTORY

**(To be completed by parent)**

**Name: __________________________ D.O.B. __________ School Yr. __________**

Parent: __________________________________ Primary Phone # __________________

Physician _________________________________________ Phone ________________

Condition(s): __________________________________________________________

Brief Description of condition(s): _______________________________________________

________________________________________________________________________________

Your child's signs and symptoms of a cardiac episode are: _________________________________________

________________________________________________________________________________

When was the last time your child was seen by a physician for this condition(s)? ____________________________

How many times has this student been seen in the emergency room in the past year for this condition(s)? ____________

How many times has this student been hospitalized in the past year for this condition(s)? ________________________

Has this student ever had surgery for this condition(s)? Type: ______________________ When: _________________

How many days would you estimate that this student missed from school or daycare last year for this condition(s)? ______

Medications: _______________________________________________________________________

________________________________________________________________________________

Equipment Needed: __________________________________________________________________

Restrictions: (If your child may not participate in physical education activities, a doctor's note is required.) _____________

________________________________________________________________________________

Field Trip Plan: ____________________________________________________________________

________________________________________________________________________________

Please add any additional information you feel is needed to safely care for your child: ___________________________

________________________________________________________________________________

**Authorization for Health Care Provider and School Nurse to Share Information:**
I authorize my child's school nurse to assess my child in regards to his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

Parent/ Guardian Signature ____________________________________________ Date ________________

Notes ___________________________________________________________________________

________________________________________________________________________________

Signature below indicates that the plan is reviewed and appropriate documentation is complete.

School Nurse Signature _______________________________________________ Date _______________