



# 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 that if your student is participating in activities before and after school, including after school care, extracurricular activities, athletics or camps, it is imperative that you inform the supervising adults of your student's medical needs.

1. What type of cardiac condition does your student have? (check all that apply)

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Aortic stenosis          | <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Rheumatic heart disease             | <input type="checkbox"/> Surgery (Type) _____  |
| <input type="checkbox"/> Coarctation of the aorta | <input type="checkbox"/> Murmur                   | <input type="checkbox"/> Tetralogy of Fallot                 | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Septal defect            | <input type="checkbox"/> Transposition of the great arteries | _____  |
|   | <input type="checkbox"/> Patent ductus arteriosus |  | _____  |

2. What are your students' usual signs and symptoms of a cardiac episode? (check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Chest tightness or pain | <input type="checkbox"/> Paleness of skin             | <input type="checkbox"/> Blue or gray color around mouth, lips, fingernails |
| <input type="checkbox"/> Shortness of breath     | <input type="checkbox"/> Change in activity tolerance | <input type="checkbox"/> Other (specify) _____                              |
| <input type="checkbox"/> Difficulty breathing    | <input type="checkbox"/> Fainting or dizziness        |   |
| <input type="checkbox"/> Tires easily            |   |   |
| <input type="checkbox"/> Irritability            |   |   |

3. How often does your student have symptoms? \_\_\_\_\_

4. List known triggers to cardiac episodes: \_\_\_\_\_

5. Does your student have any activity restrictions? Yes \_\_\_\_\_ No \_\_\_\_\_ (Physician letter is required with specific directions)

6. Does your student have any dietary restrictions? Yes \_\_\_\_\_ No \_\_\_\_\_ (Meal Modification form is required. See school for form.)

7. List current medications: \_\_\_\_\_

**As parent/ guardian of the above-named student, I understand that it is the responsibility of the parent/ guardian to notify the school of changes in health conditions. I give permission to share this information with staff on a need-to-know basis. I give consent to exchange medical information with the student's physician as needed.**

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_