Everett Public Schools
Health Services

Cardiac History Questionnaire

Student Name: ________________________________ Date of Birth: ___________________________
School: ______________________________________ School Year: ___________________________
Student Number: _______________________________ Grade: _________________________________
Parent/Guardian: _______________________________ Phone: _________________________________
Health Care Provider: ___________________________ Phone: _______________Fax_______________

Diagnosis: ____________________________________ Age at diagnosis: _______________________

Date of last cardiac episode: ______________________ Treatment: _____________________________

Brief history: ____
____
____

Hospitalizations/surgeries: ____
____
____

List any medications he/she is taking (include dosage/time given): _______________________________
____

What symptoms may occur during the school day or on a field trip that we should be aware of:
____
____
____

Are there any special accommodations required during the school day or on a field trip? ☐Yes ☐No
If Yes, ____
____
____

Disaster Preparation:
☐ I will provide 72 hours of medication in the event of a disaster (must have signed Health Care Provider orders)

Parent/Guardian Signature______________________________ Date______________________

Nurses Notes:
____
____
____
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____
____

Name: ____ Title: ___________________________