ODLSS Office of DIVERSE LEARNER SUPPORTS + SERVICES

Chicago Public Schools

H. Serv. 121

CHICAGO PUBLIC SCHOOLS

PHYSICIAN'S REPORT ON CHILD WITH A CARDIAC CONDITION

(Last Name) (First) (Middle) (DOB) (ID No.)

Home Address Zip Code Other Town

Father's Name Mother's Name Telephone

School Grade Non-Attending

Dear Doctor,

The School Nurse of Chicago Public Schools is requesting your cooperation in completing the following questions. Please return this form to the above child's school and retain a duplicate copy for your files. _____
School Nurse

DIAGNOSIS (Please Specify) _____

BREIF HISTORY (date of onset, surgeries, important signs and symptoms) _____

_____

FUNCTIONAL CLASSIFICATION (please check)

____ **CLASS I** Patients with cardiac disease, but without resulting limitation of physical activity. Ordinary physical activity does not cause fatigue, palpitation, dyspnea, or pain.

____ **CLASS II** Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or pain.

____ **CLASS III** Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea, or pain.

____ **CLASS IV** Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort or symptoms of cardiac insufficiency, even at rest. If any physical activity is undertaken discomfort is increased.

RECOMMENDATIONS

Prophylaxis treatment required ☐ Yes ☐ No Type _____

Physical restrictions ☐ No ☐ Yes ___ Gym ___Stairs ___Recess ___Diet
(Please explain)_____

Additional information and recommendations_____

_____

Daily Medication Plan

Medication Name	Dosage	Scheduled Time
1.		
2.		
3.		

LATEST PHYSICAL FINDINGS

Weight_____ Height_____ Blood Pressure_____ Pulse_____ Clubbing of fingers_____ Cyanosis_____

Thrills (intensity, location) _____Murmurs (intensity, location, character) _____

Electrocardiogram Date_____ Results_____

Physician's Name_____ **Hospital Affiliation** _____
(Please print or type)

Address _____**Telephone #** _____ **Fax #**_____

Physician's Signature _____ **Date** _____