SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
Child Development Department

Heart History

(Parent/Guardian to complete and return to Nurse)

Student Name: _____ Date of Birth: _____

Parent/Guardian: _____ School: _____

What is the name of your child's heart condition? _____

Did your child need surgery to correct this condition?

If yes, when _____

Are more surgeries needed in the future? ☐ Yes ☐ No

If yes, when _____

Please list any heart medications your child is taking:

Medication Name	Route	Dosage	Time

Will your child need to take any medication at school? ☐ Yes ☐ No

Name of medication: _____

Does your child have any activity restrictions? ☐ Yes ☐ No

If Yes, please explain: _____

Is your child on a special diet (such as salt restriction)? ☐ Yes ☐ No

If Yes, please explain: _____

Are there any special instructions or comments relating to your child's heart? ☐ Yes ☐ No

If Yes, please explain: _____

Parent Signature	Date/Phone	Nurse Signature	Date