



Individualized School Health Care Plan For Children with Wolff Parkinson White Syndrome

Name of Student: _____ DOB: _____ School Year: _____

School: _____ Homeroom teacher: _____ Grade: _____

Medical Diagnosis/Chronic Health Condition: Wolff Parkinson White Syndrome (WPW) is a heart rhythm disorder (arrhythmia) caused by a conduction abnormality in the heart. WPW can lead to extremely rapid heart rates. These arrhythmias, or abnormal heart rhythms, can produce symptoms such as palpitations, light-headedness, fainting, sometime shortness of breath or chest pain or even loss of consciousness. In very rare instances, WPW can lead to sudden cardiac arrest.

Emergency Plan: Since the child is at risk, however slight, of having a sudden cardiac arrest, it is essential that an emergency plan be in place. This plan should include the entire campus.

- If the student becomes unresponsive, look at his chest for abnormal, irregular breathing or only gasping. Call 911. There may also be some jerking movements that make you think of a seizure. Lay responders should not check a pulse.
- If the student is unresponsive and not breathing normally, begin CPR with chest compressions. As soon as an AED arrives, turn it on and follow the voice prompts. Time is critical. Each minute of delay in response can mean a decreased survival rate of 7-10%. Effective CPR will give you extra time until the AED arrives, protecting brain and heart cells. But the plan should include the AED being on the way at the same time as the first responders.
- If the student is unconscious, but is breathing normally, call 911, and observe him closely.
- If the child faints but regains consciousness quickly, observe him closely. Parents should be called and advised to seek follow up medical care.
- If the student experiences palpitations, a rapid heart rate, has chest pain or shortness of breath, the parents should be notified and advised to seek medical care.

Other considerations:

If child becomes light-headed or dizzy, experiences chest pain or shortness of breath with exercise, she/he should be allowed to sit down, and be observed by the school nurse. Occurrences of dehydration, vomiting, and/or diarrhea should also be monitored.

Because sudden cardiac arrest can occur at anytime, the school should have a designated first responder team of at least five staff members, with current CPR and AED skills. All staff should have training in recognizing a sudden cardiac arrest, location of the AEDs and activating the school's emergency response plan.

The AED should be no more than 3 minutes away and placed on the victim as soon as available. CPR can continue while the pads are being placed and until the AED calls for no one to touch the victim. Follow the voice prompts of the AED, and resume CPR when indicated. It will cycle and reevaluate the victim every two minutes. Immediate and constant attendance by first responders is paramount until EMS arrives, and parents should be notified.

Emergency Contacts:

Parent/Guardian	Relationship	Phone number	Alternate phone/contact method (including email)

Daily Medications:

Drug name	Dose	When/How Use	Side effects to observe for

Medications In Case of Emergency: _____

Special Considerations and Precautions:

Activity/PE restrictions: Self-limiting physical exercise may be allowed, however this varies from child to child. Competitive sports in many cases will be prohibited.

- ❖ If the child becomes fatigued, dizzy, short of breath or complains of chest pain, she/he must sit down, be allowed to rest, and observed closely for becoming unresponsive. The school nurse should be notified.
- ❖ On field trips and other activities away from school, an AED and a trained CPR responder should be available.
- ❖ A cell phone or other emergency communication device should always be available.

Other accommodations:

Physician name: _____ Phone number: _____

I, this child's parent/guardian hereby authorize the named healthcare provider who has attended my child to furnish to the School Health Services or School Clinic staff any medical information and/or copies of records pertaining to my child's chronic health condition, and for this information to be shared with pertinent school staff. I understand that HIPAA regulations limit disclosure of certain medical information. However I expressly authorize disclosure of information so that my child's medical needs may be served while at school. This authorization expires as of the last day of this school year.

Parent/Guardian **Signature:** _____ **Date:** _____