

H. Serv. 121, Rev 1/19

CHICAGO PUBLIC SCHOOLS
PHYSICIAN'S REPORT ON CHILD WITH A CARDIAC CONDITION

(Last Name)	(First)	(Middle)	(DOB)	(ID No.)
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Home Address	Zip Code	Other Town
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Father's Name	Mother's Name	Telephone
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School	Grade	Non-Attending
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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** _____