Stewartville School District #534

LONG QT SYNDROME EMERGENCY PLAN

(insert picture)

Date of Plan: / /

This plan is valid for the current school year: 20 ___

STUDENT INFORMATION

Name: DOB: / / Grade: School:

SIGNS AND SYMPTOMS OF LONG QT SYNDROME

Fainting
(lose consciousness)

weakness, sweating, ringing in ears, can come on suddenly

Heart

abnormal heart rhythm, palpatations, sudden death

Dizziness

feeling of faint, vertigo, loss of balance

The severity of the symptoms can change quickly.
All of the above symptoms can progress to a life-threatening situation! Know the location of all AED's.

LONG QT SYNDROME EMERGENCY PROTOCOL

1. **Unconscious for more than _____seconds. Direct someone to call 911 immediately and obtain an AED.**
2. **Check for pulse and breathing.**
3. **If no pulse and/or no breathing; Turn on the AED.**
4. **Put student in a safe area (no standing water or flammable material around).**
5. **Remove clothing from the chest, abdomen and arms, as AED pads must be used ON SKIN.**
6. **Peel covering off the AED pads and place directly onto skin as shown on the diagram.**
7. **Follow the voice directions given by the AED machine. IF INSTRUCTED TO, PRESS THE FLASHING ORANGE SHOCK BUTTON. MAKE SURE NO ONE IS TOUCHING THE UNCONSCIOUS STUDENT.**

Parent/Guardian: **Phone:** **Phone (cell):**

Parent/Guardian: **Phone:** **Phone (cell):**

Emergency Contact: **Phone:** **Phone (cell):**

Preferred Hospital:

SPECIAL CONSIDERATIONS & PRECAUTIONS:

* Portable AED machine must accompany the student during all physical activities. ☐ YES ☐ NO
* Physical activities restrictions:

PHYSICIAN'S AUTHORIZATION

OTHER PERTINENT MEDICATION	DOSAGE	TIME	SPECIAL INSTRUCTIONS:

Physician's Signature X: **Date: / /**

Physician's (Printed Name): Phone:

Clinic: Fax:

AUTHORIZATION FOR STAFF ADMINISTRATION OF MEDICATION

I understand that trained school personnel will follow the Long QT Syndrome Emergency Plan as completed by my child's physician, school nurse and myself. Further, under the delegation of the LSN/RN, I hereby give my permission that trained school personnel can administer this emergency medication in the absence of a school nurse or if my child is away from the school on a field trip or other school activity.

Parent/Guardian signature: **Date: / /**

Health Services Staff signature: **Date: / /**