MEQUON-THIENSVILLE
SCHOOL DISTRICT

Emergency Care Plan
SUPRAVENTRICULAR TACHYCARDIA

Student Name:	School Year:
Date of birth:	Grade/Teacher
Parent Contact 1	Phone #
Parent Contact 2	Phone #
Physician	Phone#
Emergency Contact info:	Preferred Hospital

Signs and Symptoms: Please check all that apply

☐ rapid heart beat >140 beats/minute ☐ Palpitations ☐ Dizziness ☐ Light Headed
☐ Breathless ☐ Chest Discomfort/Pain ☐ Low Blood pressure ☐ Syncope (fainting)

Usual treatment: _____

Medication	Dosage	Time(s)	Taken at home or school

SIGNS OF EMERGENCY: _____

Actions for teacher to take: _____

- I hereby give permission to MTSD's trained staff to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician with any concerns regarding medication administration. I agree to hold the Mequon-Thiensville School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- I allow the named physician (office) to send by electronic transmission this form to the Mequon-Thiensville School District for the purpose of continuing health care at school.
- I give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.

_____

Parent/Guardian Signature **Date**

_____

Physician Signature *(if prescription medication to be given at school)* **Date**

_____

District Nurse Signature **Date**