Chandler Unified School District #80

Vascular Access Device History

Student Name:_____DOB:_____

School:_____Grade:_____Date:_____

1. What type of Vascular Access Device does your child have? Please include size, if applicable.

   ☐ Peripherally Inserted Central Catheter (PICC)

   ☐ Central Venous Catheter (CVC)

   ☐ Implantable Venous Access Device (port)

2. What is the indication for the Vascular Access Device?

3. When was the device inserted?

4. If the device was inserted for short term use, when will it be removed?

5. Is your child currently taking medication for this condition? ☐ No ☐ Yes If yes, list name, dosage, and how often your child takes this medication. **If the medication is to be kept in the health office, Consent for Medication form must be on file.**

6. Does your child need special equipment or monitors (pump, etc)? ☐ No ☐ Yes If yes, please explain.

7. Does your child have any classroom activity restrictions (i.e. using scissors)? ☐ No ☐ Yes If yes, please explain.

8. Is there any other information about your child's Vascular Access Device you would like to share with school?

Parent/Guardian Name (Print):_____Phone No. _____

Parent/ Guardian Signature: _____Date: _____