

Medical Management Plan (Heart Conditions)



Welcome!

Thank you for registering to participate with the Raleigh Parks, Recreation and Cultural Resources Department (PRCR). The City is committed to providing all participants with an exceptional experience. The City has received your request for accommodation, and it is important that we engage you as a partner in the process to make participation as seamless and successful as possible. In order to make sure that our program is compatible with your support needs, we would like to provide you with more detailed information about our program considerations. In addition, to make sure that the City can safely and meaningfully accommodate the needs, we are requesting additional information from you and the treating physician. We would also like to further explain the steps and process for designing an accommodation to best meet your support needs, in consideration of safety and available Department resources.

PRCR Program Considerations

The Raleigh Parks, Recreation and Cultural Resources Department boasts more than 200 parks including features like amusements, art centers, athletic facilities, community centers, lakes, nature preserves, off-leash dog parks, playgrounds, swimming pools, historic homes, and open spaces. PRCR programs occur throughout all parks and facilities, on our greenways, and at non-City locations. The City cannot control environmental conditions at activities conducted off-site. Participants should plan accordingly and must notify staff in advance if alternative activities would be safer or more appropriate.

Program Activities & Requirements: Programs have various activities such as free choice play, active activities in a large room/gym/outdoors, passive/quiet activities, arts and crafts, recreational sports, games, field trips, food and food experiences, and specialty programs. Programs may involve a high level of gross motor skills and physical mobility/activity including climbing, balancing, stopping, kneeling, crouching, crawling, jumping/hopping, standing, walking, running, and physical contact between participants. Programs may involve a high level of fine motor skills as appropriate for the specific program content. In addition, participants should exhibit a moderate level of expressive and receptive communication skills and a moderate level of appropriate social skills, such as turn taking and peer cooperation.

Program Environment & Spaces: Programs may be held in a variety of spaces such as a room inside a community/art/etc. center, outdoor tennis/basketball/volleyball court, baseball/softball/open field, playground, picnic shelter, gymnasium (with or without air-conditioning), pool, etc. There may be multiple transitions between various spaces, environments and activities during the program. Some programs travel to various field trip locations, some greater than 50 miles away from the base program location. For trips, transportation may be provided by PRCR vehicles or by a charter bus. Participants may be exposed to a variety of indoor spaces both air-conditioned and not air-conditioned, and outdoor spaces in different weather conditions and temperatures. There are specific activities and spaces that will be loud (music, shouting, etc.) and some activities that will be in dim lighting (movies, video games, etc.).



Staffing: All programs operate under the direction of a full time staff that provides oversight and support to the program and instructors/staff. Some programs are instructed directly by full-time staff, while others are instructed by part-time staff. Staffing ratios and plans are unique and individualized per program. All program instructors are trained in City policies and procedures, and at least one staff with the program/facility is certified in First Aid and CPR. While there will be at least one or two staff members with First Aid and CPR certification with the program at all times, no staff members are required to have medical training or certifications above First Aid and CPR.

Needed Information

The Medical Management Plan (MMP) – please work with the treating physician to complete this form in its entirety. It is acceptable for a participant/parent/guardian to fill out the form as long as the physician reviews and signs it. The City will rely on this form in order to make reasonable attempts to make accommodations and provide an opportunity to meaningfully participate in program activities. Because the City has no staff with medical training or experience specific to particular limitations and needs, Parks, Recreation and Cultural Resources staff must rely on the MMP in order to safely supervise the participant. The MMP must be returned to the City at least two weeks before the start of the program. However, in order to allow as much time as possible for development of a support plan, to allocate available resources, and to provide additional training, the City would like to receive the MMP back from you as far in advance as possible. The form is attached to this letter and includes an overview for the physician.

Next Steps

PRCR staff will review the MMP once it is received to determine whether PRCR resources are adequate to safely accommodate.

- If we are able to accommodate, PRCR staff will contact you and will work with the participant/parent/guardian to develop an appropriate support plan. Medical accommodations are the most successful when we work directly with the treating physician and the participant/parent/guardian to develop the support plan and offer training for the program staff. Effective communication between the City and the participant/parent/guardian will be essential to the development of a care plan that accurately reflects the care needs. After the support plan has been developed, PRCR staff will work with you to verify how staff will implement the procedures.
- We will work collectively to schedule and conduct appropriate training for the staff that will be working to provide support. The City asks that you be available during the training to share with staff any pertinent information, and to partner with any appropriate medical staff to provide information about any equipment or situations that may be unique.

Please let us know as you have questions. We look forward to serving you in our programs!

Sincerely,

Laurel Heizelman, LRT/CTRS, CPRP
Inclusion Manager
Specialized Recreation and Inclusion Services
919-996-2149

Christen Winstead, LRT/CTRS, CPRP
Program Director
Specialized Recreation and Inclusion Services
919-996-2111

Medical Management Plan (Heart Conditions)



Dear Physician:

One of your patients has registered to participate in a City of Raleigh Parks, Recreation and Cultural Resources Department program or event, and we have been requested to provide support for care. Please review the program considerations below and discuss the specific program with your patient. Then, please complete the attached Medical Management Plan (MMP) in full. This record will remain in the participant's file so that we may assist with their medical care and needs. The completed MMP will be valid for one calendar year from the date of your signature, unless there are changes in their condition.

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with the program/facility is certified in First Aid and CPR. While there will be at least one or two staff members with First Aid and CPR certification with the program at all times, no staff members are required to have medical training or certifications above First Aid and CPR.

If you have any questions regarding the MMP or more specific program considerations, please contact us.

Sincerely,

Laurel Heizelman, LRT/CTRS, CPRP
Inclusion Manager
Specialized Recreation and Inclusion Services
919-996-2149
Laurel.heizelman@raleighnc.gov

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Medical Management Plan (Heart Conditions)



This plan is designed for participants under the age of 18 or those over the age of 18 who may need support managing their condition. It should be completed by the participant's personal health care team, including the parent/guardian. It should be reviewed with relevant Parks, Recreation and Cultural Resources staff and copies should be kept in a place that can be accessed easily by authorized personnel. This plan is valid for one year from the physician's signature unless condition or care changes.

Participant's Name:

Date of Birth:

Diagnosis:

Date of Diagnosis:

Program:

Location:

Program 2 (if applicable):

Location:

Additional Programs and Locations:

CONTACT INFORMATION

Guardian:

Address:

Telephone: (H)

(W)

(C)

Email Address:

Guardian:

Address:

Telephone: (H)

(W)

(C)

Email Address:

Participant's Physician/Health Care Provider:

Address:

Email Address:

Telephone:

Emergency Number:

Other Emergency Contact:

Name:

Relationship:

Telephone: (H)

(W)

(C)

CARDIAC CONDITION AND ACTIVITY

What is the participant's diagnosis?

Please explain the general condition:

Please list any signs or symptoms of a cardiac episode:

Are there any known triggers for cardiac episodes? Yes No

Please explain:

How long do cardiac episodes typically last?

How does the participant react during a cardiac episode?

How does the participant react after a cardiac episode?

Describe what constitutes an emergency for the participant's cardiac condition:

CARDIAC HISTORY

When was the participant's last cardiac episode (Month and Year):

How frequently do cardiac episodes occur?

Daily

Weekly

Monthly

Other:

Has the participant ever been hospitalized due to their condition? Yes No

Have there been any recent changes to the participant's cardiac patterns? Yes No

CARDIAC PROCEDURES

Describe the steps staff should follow when the participant has a cardiac episode. Please clearly indicate when CPR should be initiated, etc.

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

When should parents be contacted?

When should 911 be called?

AED: For the participant's cardiac plan, is an AED needed? Yes* No

*If yes, please answer the following questions:

Does an AED always need to be with the participant? Yes No

If no, please explain:

Does an AED need to be taken on field trips? Yes No

Will parents/guardians be providing an AED? Yes No

Do PRCR staff need to be trained in CPR/AED? Yes No

Please explain:

MEDICATIONS

Please list medications/supplements (and dosages) participant takes outside program hours:

Please list routine/daily medications to be given by PRCR staff during program hours:

Medication	Dosage	Frequency/Time
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Please list medications to be administered as emergency response outlined on pg 3:

Medication	Dosage	Timing of Administration*	Method of Administration**
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*Immediately, after 1 minute, 10 minutes, etc. **Orally, under tongue, injected, etc.

PROGRAM CONSIDERATIONS

Check all that apply and describe consideration or precautions that should be taken (please attach additional pages if needed):

Field Trips:

Outdoor
Activities:

Physical
Activity:

Swimming:

Water Activities
(ie. boating,
lake activities):

Weather
Conditions:

Other:

Additional Information or special instructions for care:

Please continue to next page.

SIGNATURES: PHYSICIAN

As the treating physician of (participant's name) _____, I have reviewed the program description, likely environmental conditions, and physical requirements of (program name) _____. In my judgment, I believe (participant's name) _____ may safely participate in (program name) _____ and that the physical limitations of (participant's name) _____ may be successfully met by non-medical personnel. Therefore, I (physician) approve this Medical Management Plan and acknowledge that the procedures outlined in this plan may be performed by non- medical personnel.

Participant's Physician/Health Care Provider Name

Participant's Physician/Health Care Provider Signature _____ Date _____

I intend and agree that typing my name above constitutes my electronic signature, which acknowledges my consent to the terms set forth herein. I intend that my electronic signature have the same legal force and effect as a written signature. I consent to using electronic means by which to provide written authorization for the Medical Management Plan and procedures for the above referenced participant, and further agree that I have provided the written authorization as required by law.

Heart Condition Management Procedures

***To be completed by the parent/guardian.**

I acknowledge that the ability of PRCR staff to successfully implement (participant's name) 's MMP depends on the timeliness and accuracy of the information provided herein. I further acknowledge that PRCR staff will rely upon the information provided herein in order to make reasonable efforts to:

- Provide care consistent with the most current approved MMP
- Provide accurate, timely information about the scheduled activities and program environment
- Train staff on all procedures outlined in the MMP who will be responsible for providing care
- Ensure trained personnel are with the participant/on-site at all times during the program
- Document care provided as it is given using approved documentation
- Provide adequate space as needed for care
- Provide appropriate storage, access, and disposal for medication and equipment
- Communicate with the parent/guardian as outlined in the communication protocol

Parent/Guardian will:

Provide accurate, timely information regarding the most current approved MMP and any future updates or changes to the plan (when possible at least 2 weeks in advance)

Participate in training staff of the Raleigh Parks, Recreation and Cultural Resources Department as requested to review equipment and/or procedures that are specific to the participant

Provide all medication and medical equipment needed to implement the approved MMP in the program

Communicate with Raleigh Parks, Recreation and Cultural Resources as outlined in the communication protocol

Medication storage/access:

The following medications will be provided to the program in accordance with the approved MMP and have the following storage/access requirements:

Medication:

Storage:

Access: On-site (access in less than 10 minutes, ie. stored in office)
Immediate (medication must be with participant at all times)

Medication:

Storage:

Access: On-site (access in less than 10 minutes, ie. stored in office)
Immediate (medication must be with participant at all times)

Medication:

Storage:

Access: On-site (access in less than 10 minutes, ie. stored in office)
Immediate (medication must be with participant at all times)

Communication protocol:

I request that Parks, Recreation and Cultural Resources staff contact the parent/guardian immediately in the following circumstances:

Any time the participant's emergency action plan is activated

Any time there are concerns regarding the participants engagement in the program that may be medically related

For any circumstance compromising PRCR's ability to provide care

Parks, Recreation and Cultural Resources will contact the parent/guardian:

To discuss special program circumstances that could impact care (examples include field trips, overnights, program provided food)

Parent/Guardian will contact PRCR:

Any time the participant's MMP or management procedures need to be updated

Any time changes in the participant's medical condition could cause care during the program to be problematic

Any time the participant will be absent from the program

Additional information or responsibilities:

SIGNATURES: PARENT/GUARDIAN

I, (parent/guardian) _____ give permission to the personnel of the City of Raleigh Parks, Recreation and Cultural Resources Department to perform and carry out the care tasks as outlined in (participant's name) _____ Medical Management Plan.

I understand and acknowledge that the City of Raleigh is not a healthcare provider, and that this document contains protected health information regarding (participant's name) _____. I freely authorize disclosure of this information to the City of Raleigh for the purposes stated herein, and I understand that the information used or disclosed herein may be subject to re-disclosure, and that disclosure of this information may mean that this information is no longer protected by Federal privacy regulations. I expressly consent to the release of the information contained in this Medical Management Plan to all program staff members and other adults who have responsibility for the participant's and who may need to know this information to maintain my child's health and safety. I also give permission to the PRCR staff and/or qualified health care professional to contact the participant's physician/health care provider. I understand that any action already taken in reliance on this authorization cannot be reversed.

Participant's Parent/Guardian Name

Participant's Parent/Guardian Signature

Date

I intend and agree that typing my name above constitutes my electronic signature, which acknowledges my consent to the terms set forth herein. I intend that my electronic signature have the same legal force and effect as a written signature. I consent to using electronic means by which to provide written authorization for the Medical Management Plan and procedures for the above referenced participant, and further agree that I have provided the written authorization as required by law.

Acknowledged and received by:

PRCR Authorized Representative

Date