Medical Management Plan — CYSTIC FIBROSIS

SCHOOL YEAR 2016-2017

Student Name: _____ Date of Birth: _____

Physician's Name: _____ Phone #: _____

Address: _____ Fax #: _____

Symptoms:

- ☐ Persistent coughing, at times with mucus
- ☐ Wheezing or shortness of breath
- ☐ Recurrent respiratory infections
- ☐ Fatigue
- ☐ Upset stomach

Medications taken at home: _____

Medications needed at school: ☐ Yes ☐ No If yes please list: _____

Enzymes needed at school: ☐ Yes ☐ No Enzyme brand name: _____

 # to be taken with snack: _____ **# to be taken with meals:** _____

For Self Administration of Enzymes:
It is my professional opinion that _____ (Student name) ☐ should ☐ Should **NOT** carry and use enzymes by him/herself.

Special equipment needed at school? ☐ Yes ☐ No _____

Dietary modifications? (please list) _____

Activity restrictions (excuse from physical education requires a physician's note) _____

Fluids needed with physical activity? ☐ Yes ☐ No What type is needed? _____

Other modifications needed? (i.e. frequent bathroom breaks): _____

Nursing services are recommended for the care of this student during the school day.

Physician's Signature: _____ **Date:** _____

Continued Cystic Fibrosis Plan for (Student NAME) _____

Is your child compliant with their current treatment regime?	Yes		No	
Does your child function independently with medication administration?	Yes		No	
Are there any activity restrictions for your child?	Yes		No	

If yes, please list: _____

PARENT to Complete: Authorization for Health Care Provider and School Nurse to Share Information

I authorize my child's school nurse to assess my child as it relates to his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

As the parent or guardian of the student named above, I request that the principal or principal's designee assist in the administration of medication/treatment prescribed for my child.

I understand that under provisions of Florida Statue 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administrating such medication acts as an ordinarily reasonable, prudent person would have acted under the same or similar circumstances. I also grant permission for school personnel to contact the physician listed above if there are any questions or concerns about the medication. I have read the guidelines and agree to abide by them. I authorize the physician to release information about this condition to school personnel.

Parent/Guardian Signature	**Print Name**	**Date**

Parent/Guardian: _____ Cell: _____

Work: _____

Parent/Guardian: _____ Cell: _____

Work: _____