

## Medical Management Plan

## CYSTIC FIBROSIS

SCHOOL YEAR: \_\_\_\_\_

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

List Known ALLERGIES: \_\_\_\_\_

### Symptoms:

☐

Persistent coughing, at times with mucus

☐

Fatigue

☐

Wheezing or shortness of breath

☐

Upset stomach

☐

Recurrent respiratory infections

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 \_\_\_\_\_ ☐ should ☐ Should **NOT** carry  
and use enzymes by him/herself. Student name

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: \_\_\_\_\_

ST. JOHNS COUNTY SCHOOL DISTRICT

**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/GUARDIAN 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 Statute 1006.062, there shall be no liability for civil damages as a result of the administration of medication when the person administering 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: \_\_\_\_\_