

Medical Management Plan
SCHOOL YEAR 2019-2020

CYSTIC FIBROSIS

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 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: _____