# Medical Management Plan — CYSTIC FIBROSIS

## SCHOOL YEAR 2017-2018

Student Name: _____ Date of Birth: _____

Physician's Name: _____ Phone #: _____

Address: _____ Fax #: _____

List Known ALLERGIES: _____

**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: _____