

**Medical Management Plan**

**CYSTIC FIBROSIS**

**SCHOOL YEAR 2022-2023**

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

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

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

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

**Symptoms:**

<input type="checkbox"/> Persistent coughing, at times with mucus	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Wheezing or shortness of breath	<input type="checkbox"/> Upset stomach
<input type="checkbox"/> Recurrent respiratory infections	

**Medications taken at home:** \_\_\_\_\_

**Medications needed at school:**  Yes  No      If yes please list: \_\_\_\_\_

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**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) \_\_\_\_\_

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**Activity restrictions** (excuse from physical education requires a physician's note) \_\_\_\_\_

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Fluids needed with physical activity?  Yes  No      What type is needed? \_\_\_\_\_

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

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*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	<input type="checkbox"/>	No	<input type="checkbox"/>
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Does your child function independently with medication administration?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Are there any activity restrictions for your child?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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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
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Parent/Guardian \_\_\_\_\_ Cell: \_\_\_\_\_

Work: \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Cell: \_\_\_\_\_

Work: \_\_\_\_\_