

Medical Management Plan
SCHOOL YEAR 2023-2024

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 | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

Does your child function independently with medication administration?

| | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

Are there any activity restrictions for your child?

| | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

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 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: _____