CYSTIC FIBROSIS MEDICAL MANAGEMENT PLAN

(To be completed by Physician/ Healthcare Provider)

PLACE I.D. PHOTO HERE

Name: ________________________ **D.O.B.** __________ **School Yr.** ____________

Parent: ____ Primary Phone # ________________________

Physician ____ Phone _____________________

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 ____

Enzymes Needed at School: ☐ Yes ☐ No Enzyme Brand Name ____________________________________

to be taken with snacks ___________________________ # to be taken with meals ___________________________

For Self Administration of Enzymes:

☐ It is my professional opinion that ______________________________ ☐ should ☐ should **NOT** carry and use the enzymes by him/ herself.

Special Equipment Needed at School ☐ Yes ☐ No ____

Dietary Modifications: ____

____

Activity restrictions (excuse from physical education program will require a doctor's note): ______________________________

____

Fluids needed with physical activity ☐ Yes ☐ No What type is needed?______________________________________

Other modifications needed (i.e. frequent bathroom breaks): ____

Physician Signature____ **Date** __________________

Nursing services are recommended for the care of this student during the school day.

Authorization for Health Care Provider and School Nurse to Share Information: For Parent to Complete

I authorize my child's school nurse to assess my child as regards 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 ____________

Phone (C) ________________________ (WK) ________________________ (HM) ________________________