## 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 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 and use enzymes by him/herself.  Student name	should Should <b>NOT</b> carry		
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:		

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## ST. JOHNS COUNTY SCHOOL DISTRICT

Continued Cystic Fibrosis Plan for (Student NAM)	E)		
Is your child compliant with their current treatment re Does your child function independently with medication Are there any activity restrictions for your child? If yes, please list:		Yes No No No No No No	
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:		
Parent/Guardian	Work: Cell:		
	Work:		

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