

Medical Management Plan

CYSTIC FIBROSIS

SCHOOL YEAR: 2026-27

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: _____

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:** _____

