**ST. JOHNS COUNTY SCHOOL DISTRICT**
**SCHOOL HEALTH SERVICES**

# 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) _____