ST. JOHNS COUNTY SCHOOL DISTRICT

Medical Management Plan

CYSTIC FIBROSIS

SCHOOL YEAR 2024-2025

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 ______________ (Student name) ☐ should ☐ Should **NOT** carry and use enzymes by him/herself.

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:** ______________

Continued Cystic Fibrosis Plan for (Student NAME) ______________________________

	Yes		No	
Is your child compliant with their current treatment regime?	Yes	☐	No	☐
Does your child function independently with medication administration?	Yes	☐	No	☐
Are there any activity restrictions for your child?	Yes	☐	No	☐

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 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: ______________________

Work: ______________________

Parent/Guardian ______________________ Cell: ______________________

Work: ______________________