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:** _____

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Continued Cystic Fibrosis Plan for (Student NAME) _____

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/GUARDIAN 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: _____