HEALTH MANAGEMENT PLAN
CYSTIC FIBROSIS
SCHOOL YEAR: _____

STUDENT NAME:	**DOB:**
SCHOOL:	**STUDENT ID:**
CONTACTS:	
MOTHER:	**FATHER:**
HOME:	**HOME:**
WORK:	**WORK:**
CELL:	**CELL:**
If parents cannot be reached call:	
Name:	**Phone:**
Name:	**Phone:**
Physician:	**Phone:**
Hospital Preference:	

BASIC INFORMATION: Cystic Fibrosis is a chronic, genetic disease resulting in the formation of a thick, sticky mucous which leads to severe respiratory and digestive problems. Treatment consists of various airway clearance therapies via medications and chest percussion as well as taking enzymes with every meal and snack to aid digestion. It is not contagious and affects each person differently.

STUDENT HISTORY:_____
_____

GUIDELINES FOR SCHOOL:

1. COUGHING: Have box of tissues at student's desk. Other measures:_____
   _____
2. WATER & RESTROOM PRIVILEGES: Allow student to have water bottle in class and to use restroom as needed without hesitation.
3. NUTRITION: Allow student to have extra snack as needed.
4. MEDICATIONS before all meals and snacks:_____
   _____
5. ACTIVITY ___LIMITATIONS:_____

CALL PARENTS IF: Student has fever, shortness of breath, pale skin color, fatigue and weakness, abdominal pain that increases, vomiting, cough that is blood tinged, or any other signs of illness or injury while at school.

CALL 911 IF STUDENT IS UNABLE TO CATCH HIS/HER BREATH OR TURNS DUSKY OR BLUE AT LIPS, CHANGE IN LEVEL OF CONSCIOUSNESS, COUGHING OR VOMITING BLOOD.

School Clinic: Copy of plan should be provided to Transportation Supervisor

_____ _____
PARENT SIGNATURE / DATE COUNTY SCHOOL NURSE SIGNATURE/ DATE

Confidentiality must be upheld when talking to other parents or outside persons .Information about students and family is strictly confidential.
Rev 5/10, 3/2013, 4/2016 .