Cystic Fibrosis Care Plan
Medication Authorization & Self-Administration Form

School Year:

STUDENT INFORMATION:

Student:	DOB:	School:	Grade:
Parent:	Phone:	Email:	
Physician:	Phone:	Fax:	
District Nurse:	School Phone:	School Fax:	

Brief Medical History:

PHYSICIAN TO COMPLETE:

SYMPTOMS	MEDICATIONS PRESCRIBED
Shortness of Breath, Wheezing or Chest tightness: • Rest as needed during PE or other exercise • Contact parent for continued symptoms • **Use rescue inhaler *(if applicable)***	Medication: _____ Dose: _____ Interval: _____ Medication: _____ Dose:_____ Interval: _____
Eating/Caloric Intake: • Allow snacks with appropriate medications • High calorie/high fat snacks are appropriate • **Pancreatic Enzymes *(if applicable)***	Medication: _____ Dose: _____ Interval: _____ Medication: _____ Dose:_____ Interval: _____

Excessive Coughing:
- Encourage good hygiene (use tissues)
- DO NOT discourage coughing
  Keep water available: (helps thin secretions)

Stomach Pain/Cramps:
- Bathroom privileges at all times
  Call parent/guardian as needed for stomach pain or complaints

Excessive Sweating/Salt Secretions:
- Limit outside activity on hot days/provide shade
  Encourage adequate liquid intake (Gatorade)

Absences:
- Excuse absences due to sickness or infection
  Accommodate work according to illnesses/hospitalizations

Respiratory Distress: EMERGENCY CARE
If student is unable to talk, breathing is hard and fast
- Position student with chest at 45 degree angle
- Use rescue inhaler (if applicable)
- If medication is not working and symptoms become more severe, **CALL 911**
- Notify Parent and District Nurse

PHYSICIAN SIGNATURE:

The above named student is under my care.

- ☐ **It is** medically appropriate for the student to self-carry and administer medication, when able and appropriate, and be in possession of Cystic Fibrosis medication and supplies at all times. The medications prescribed for this student is/are identified above.
- ☐ **It is not** medically appropriate for the student to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain this student's medication for use if having symptoms.

_____ _____ _____

Healthcare Provider (print): Signature Date

PARENT TO COMPLETE:

Parental Responsibilities:

- The parent of guardian is to furnish all medication and bring to the school in the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare providers name.
- The parent or guardian, or other designated adult will deliver to the school and replace all medication when empty.
- If a student has a change in his/her prescription, the parent or guardian is responsible for providing the newly prescribed information and dose information as described above to the school. The parent or guardian will complete an updated Cystic Fibrosis Care Plan before the designated staff can administer the updated medication prescription.

Parent/Guardian Authorization:

- ☐ **I authorize** my child to self-administer and carry the prescribed medication described above. My student is responsible for, and capable of possessing or possessing and self-administering the above named medication (per UCA 53A-11-602). My child and I understand there are serious consequences for sharing any medication with others.
- ☐ **I do not authorize** my child to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain my child's medication for use in an emergency.
- ☐ **I authorize** the appropriate/designated school personnel maintain my child's medication for use in an emergency.

As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to administer medication and follow protocol as identified in the Cystic Fibrosis Care Plan. I agree to release, indemnify, and held harmless the above from lawsuits, claim expense, demand or action, etc., against them for helping this student with treatment, provided the personnel are following physician instruction as written in the Cystic Fibrosis Care Plan. Parent/Guardians and students are responsible for maintaining necessary supplies, medication and equipment. I give permission for communication between the prescribing health care provider, the school nurse, the school medical advisor and school-based clinic providers necessary for Cystic Fibrosis management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent/guardian to notify school staff whenever there is any change in the students health status or care.

_____	_____	_____
Parent Name (print)	Signature	Phone
_____	_____	_____
Emergency Contact	Relation	Phone

DISTRICT NURSE TO COMPLETE: (or Principal Designee if no School Nurse)

- ☐ Signed by Physician and Parent
- ☐ Medication is appropriately labeled
- ☐ Medication log is generated

Medication is kept:

- ☐ Student self carries
- ☐ Classroom
- ☐ Health Office

Cystic Fibrosis Care Plan has been distributed to need to know staff:

- ☐ Teachers
- ☐ PE Teachers
- ☐ Transportation Department

_____	_____
District Nurse Signature	Date