Cystic Fibrosis Action Plan

To be completed by Physician/ Healthcare Provider)

Place Student's Picture Here

Student: _____ Grade: _____ DOB: _____
Teacher: _____Classroom: _____School Year: _____
Physician _____ Phone _____

Symptoms:
Persistent coughing, at times with mucus ☐ fatigue ☐ wheezing or shortness of breath ☐ upset stomach ☐ recurrent respiratory infections ☐ smaller stature ☐ foul-smelling stools ☐ poor appetite ☐

Please check appropriate boxes:

☐ No ☐ Yes Special diet requirements:_____
☐ No ☐ Yes Enzymes, needed at school (name)_____
☐ No ☐ Yes Nebulizer/Inhaler needed at school(name)_____
☐ No ☐ Yes Activity restrictions:_____
☐ No ☐ Yes Special Equipment Needed at school :_____
(If yes, parent must provide any special equipment needed while student is at school)

Action Plan:

If difficulty breathing	**Call 911 if this happens**
• Stay calm and reassure student • Stay with student • Have student use inhaler, if available • Have student drink warm water • Call parent • Other:_____ _____ _____	• Chest/neck retracting when breathing • Student is hunched over • Student is struggling to breath • Blue lips or fingernails • Difficulty walking or talking • Other:_____ _____ _____

Classroom Information/Accommodations (as needed):

- Allow the student to cough as needed – never encourage them to suppress their cough.
- Exercise and activities at recess and PE should be as tolerated.
- Allow frequent rest periods as needed and indicated by student.
- If sending student anywhere, send with an escort
- Other:_____
- _____

Provider Signature & stamp: _____Date: _____
Parent/Guardian Signature: _____ Date: _____
Parent/Guardian Name: _____