Place Student's Picture Here

Cystic Fibrosis Action Plan

To be completed by Healthcare Provider

Student: _____ Grade: _____ DOB: _____
Teacher: _____ Classroom: _____ School Year: _____
Healthcare Provider _____ 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 (If yes, complete FM5425):_____
- ☐ No ☐ Yes Enzymes needed at school (name): _____
- ☐ No ☐ Yes Nebulizer/Inhaler needed at school: _____
- ☐ No ☐ Yes Special Equipment needed at school: _____
- ☐ No ☐ Yes Activity Restrictions: _____

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: _____ • Other _____ • Other: _____ • Other: _____	• Chest/neck retracting when breathing • Student is hunched over • Student is struggling to breath • Blue lips or fingernails • Difficulty walking or talking • Other: _____ • Other _____ • Other: _____ • 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: _____
- Other: _____

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