SUMTER COUNTY SCHOOLS
INDIVIDUALIZED HEALTH CARE PLAN CYSTIC FIBROSIS

Student Name: ______________________________ DOB: ______________ School: ________________ Grade: _____________
Parent/Guardian: ____________________________ Phone: Home ______________Cell ______________Work ______________
Emergency Contacts: _________________________ Phone: Home ______________ Cell______________ Work______________
Healthcare Provider: __________________________________ Phone: ____________________ Fax: ____________________
Medical Diagnosis: ____________________________________ Allergies: ____
Medications/Home: ____________________________________ At School: ____

ESE: _____Yes _____ No **IEP:** _____ Yes _____ No **504:** _____Yes _____ No

Parent Signature: __________________________________ Date: ___________ Preferred Hospital: _______________

NURSING DIAGNOSIS	GOALS	INTERVENTIONS	EVALUATION	DATE
___ Ineffective airway clearance R/T alteration in respiratory status. Nursing Assessment Information: ___ Per Healthcare provider ___ Per Parent/Guardian	____ Student will maintain optimal respiratory function and will follow airway clearance procedures at school.	____ Administer prescribed inhaled medication. ____ Reinforce coughing techniques. ___ Auscultate breath sounds to determine effectiveness of airway clearance techniques. ____ Encourage adequate fluid intake.	____ Student will use effective cough maneuvers to clear airway.	Date Initiated: ___________ Date Reviewed: ___________ Date Reviewed: ___________ Date Reviewed: ___________ Date Discontinued: ___________
____ Alteration in nutrition related to Chronic Illness (Cystic Fibrosis).	____ Student will maintain good nutritional management	____ Encourage foods high in protein and calories. ____Administer medication (enzymes supplements), if prescribed by health care provider, to assist with met adsorption. ____ Encourage student to eat snacks that are needed during the school day. ____ Maintain weight	____ Student will consume 65% of recommended daily caloric intake during school day.	Date Initiated: ___________ Date Reviewed: ___________ Date Reviewed: ___________ Date Reviewed: ___________ Date Discontinued: ___________
____ Potential for change in medical status	____ Student/family will collaborate with school staff and health care team to facilitate optimum health necessary for learning.	____ Parent will provide school with current medical information at the beginning of the school year/upon initial diagnosis of condition and as changes occur. ____ The school nurse will call health care	____ Student/Parent will report any changes in student condition or any changes in medical management of student's chronic condition.	Date Initiated: ___________ Date Reviewed: ___________ Date Reviewed:

		provider to obtain current information when necessary to safely manage student's condition at school. ____ If needed, trained school personnel will accompany student on field trips/other off campus school related activities.		____________ Date Reviewed: ____________ Date Discontinued: ____________
____ Alteration in bowel elimination (Fatty foul smelling stools).	____ Student will maintain near normal stools.	____ Provide easy access the bathroom.	____ Student will have access to the bathroom as needed.	Date Initiated: ____________ Date Reviewed: ____________ Date Reviewed: ____________ Date Reviewed: ____________ Date Discontinued: ____________

Nurse Signature: ______________________________ Date: ____________

Nurse Signature: ______________________________ Date: ____________

Nurse Signature: ______________________________ Date: ____________

Nurse Signature: ______________________________ Date: ____________