Individual Health Plan
Cystic Fibrosis

Completed by Health Care Provider

Student Photo

Name: Birth Date:

Diagnosis:_____

Brief description of condition:_____

How would this current condition adversely affect student's educational performance?_____

_____

Home medication and dosage:_____

_____

Possible side effects of medication that school personnel need to be aware of:_____

_____

Symptoms:

Respiratory	Chronic cough, noisy breathing and wheezing, chronic inflamed sinuses
GI	Chronic digestive problems, large, foul-smelling stools, stomach aches, poor appetite

Action Plan: If sending student having difficulty breathing anywhere, send with an escort

If difficulty breathing	**Call 911 if this happens**
• Stay calm and stay with student • Have student use inhaler, per Health Care Provider Order's • Have student drink warm water • Call parent • If improvement takes place, student may return to class after 15 minutes' observation • Other:	• Chest/neck retracting when breathing • Student is hunched over • Student is struggling to breath • Blue lips or fingernails • Difficulty walking or talking • No improvement 15" after using inhaler • Other:

Please check appropriate boxes *(Medication orders required):

☐ No ☐ Yes Special diet requirements:_____
☐ No ☐ Yes *Enzymes, per Health Care Provider's orders
☐ No ☐ Yes *Nebulizer/Inhaler per Health Care Provider's orders
☐ No ☐ Yes Flutterer, how often:_____
☐ No ☐ Yes Monitor weight, how often:_____
Further recommendations from HCP: (classroom, school bus, field trips, disaster, PE restrictions etc.):_____
_____

Medication required for student to attend school, complete the following.

Name of Medication(s) needed at school	Dose	Time of day to be given
Side effects of drug (if any) to be expected:		
Length of time this authorization is valid (no longer than current school year):		

I request and authorize this student to carry their medication/self-administer.
They have demonstrated proper use in my office. **Yes** **No** **School Nurse approval**_____

Health Care Provider Signature:	Date:
Health Care Provider name (print or type)	
Phone: Fax:	
School Nurse Signature:	Date:

Parent Permission (*to be completed by parent or guardian*)

- By law my signature indicates that I understand the district shall incur no liability as a result of any injury arising from the administration of medication by the KSD staff or as self-administered by the student.
- Parents or guardians shall hold harmless the district and its employees or agents against any claim arising out of the self-administration of medication.

Signature of parent or guardian: _____ Date: _____

MEDICATION AT SCHOOL RULES

- Prescription medications must be in the original labeled container from the pharmacy.
- Over-the-counter medication must be in the original container.
- Any changes to this medication will require a new medication form completed by both parent and health care provider.
- Under normal circumstances prescribed **oral, nasal spray, topical, eye drop or ear drop** medication and over-the-counter **oral, nasal spray, topical, eye drop or ear drop** medication should be dispensed before and/or after school hours under supervision of the parent / guardian.
- Medications will only be dispensed at school when failure to receive the medication may result in the student being unable to attend school or to be well enough to participate in learning activities.
- If a student must receive prescribed or over-the-counter medication during school hours, the parent must submit a Medication at School form completed and signed by both the parent and a licensed heath care provider.
- Only the amount of medication needed during school hours for the course of the illness/condition is to be sent to school, not to exceed a one month's supply.
- Medications that must be given in half-pill doses must be cut by the pharmacy or the parent. The school will not cut pills.
- Parent or designated adult to bring medication to school (students should not transport medication to school).
- When the duration of a medication is complete or out of date, or at the end of the school year, the parent must pick up any unused portions of the medication. Unclaimed medications will be discarded.
- Bus drivers will not transport or administer medication.
- In case of necessity, the school district may discontinue administration of the medication with proper advance notice.

Authorization for Mutual Exchange of Confidential Information

Purpose: *As a parent, guardian or student, you have the right to give permission or not give permission for the release of your child's records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the Family Education Right and Privacy Act. FERPA, (for example, transfer of records from one school district to another).*

Student Name: _____ Date: _____ DOB: _____

I hereby authorize the release of records

From:		***To:***	
Agency/Person:		**Agency/Person:** ***KSD Nurse***	
Street Address:		**Street Address:**	
City, State, Zip:		**City, State, Zip:** ***Kennewick, WA,***	
Tel:	***Fax:***	***Tel: 509-222-***	***Fax: 509-222-***

Describe records to be disclosed: ***Diagnoses, medication, medical recommendations applicable for student at school.***

The reason for disclosing the record(s) is: ***To provide safe care of the student in the educational setting***

This authorization is valid from: _____/_____/_____ to: _____/_____/_____.

I understand that this information obtained will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards by a school district and not the Health Insurance Portability and Accountability Act (HIPAA).

I understand my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

Parent/guardian/student signature:	Date: