Post Falls School District #273
School Nursing Services
206 W. Mullan Ave, Post Falls ID 83854
PO Box 40, Post Falls, ID 83877
(208) 773-6976

Cystic Fibrosis Information

Dear Parent/Guardian:

If your child has cystic fibrosis please complete this form and return it to your child's school.

Student's Name: _____
School: _____ Grade: _____ Teacher: _____
Parent/Guardian: _____Phone: _____
Physician's Name: _____ Phone: _____

1. When was your child diagnosed with cystic fibrosis? _____
2. How many times has your child been hospitalized in the past? _____
3. How does cystic fibrosis affect your child? _____
4. If your child has breathing problems, what are the triggers? ☐ Cold air ☐ Strong odors ☐ Smoke ☐ Other:_____
5. Is your child on a modified diet? _____
6. Does your child take medication for CF? ☐ Yes ☐ No

Please list all medications prescribed, supplements or over the counter:

Medications	**Dose/Time**	**Side Effects:**

If your child needs medication at school, please bring the medication to the school office in the original container (an extra prescription bottle may be prepared for school at the pharmacy).

*An **Authorization for Medication Administration** form will need to be completed.*

7. If your child needs an inhaler at school it is strongly encouraged to keep a rescue inhaler in the school office. Students should be able to tell an adult when they are having trouble with their asthma and know not share the inhaler.
☐ Inhaler to be kept in the office ☐ My child is aware of these expectations and will carry his/her own inhaler.
Student will carry Emergency inhaler in: _____

8. If the school nurse has more questions regarding this form what is your preferred method of contact?
☐Phone or ☐ Email: _____

Parent/Guardian's signature: _____ Date: _____

Thank you,
Elizabeth Costin, BSN, RN
Post Falls School District Lead Nurse

Revised: June 2020