CANCER MANAGEMENT PLAN
School Year: _____

STUDENT:	**DOB:**
SCHOOL:	**STUDENT ID:**

CONTACTS:	
MOTHER:	**FATHER:**
HOME:	HOME:
WORK:	WORK:
CELL:	CELL:

IF PARENTS CANNOT BE REACHED CALL:	
Name:	Phone:
Name:	Phone:
PHYSICIAN:	PHONE:
PHYSICIAN:	PHONE:
HOSPITAL PREFERENCE:	

BRIEF HISTORY: (Include medications)

SYMPTOMS: (Circle those that apply)

-fatigue/lethargy - mouth sores - pale complexion
-shortness of breath - bruising/bleeding - fever/decreased immunity
-nausea/vomiting - abdominal pain - short attention span

MANAGEMENT: IV Access/Location: _____

- Avoid injury to IV access site/secure external tubing/have clamp available
- Allow area for rest as needed
- Allow snacks/water as needed
- Avoid sources of potential infections
- Administer medications as needed
- Notify parent of elevation in temperature or other symptoms

CALL PARENTS IF:

- Symptoms interfere with ability to participate in class activities
- Fever
- Vomiting
- Unrelieved pain
- Infectious disease outbreak in classroom/school
- IV access site shows signs of infections: redness, swelling, increased warmth of skin, drainage or odor.

CALL 911 IF: Student collapses, has uncontrolled bleeding or severe pain, sudden shortness of breath, symptoms of shock or alteration in level of consciousness. If IV access site is pulled loose and bleeding: clamp, apply pressure to site and have 911 evaluate.

Copy of this plan has been provided to Transportation Supervisor Yes □ No □

_____ _____

Parent Signature Date County School Nurse Signature Date

Confidentiality must be upheld when talking to other parents or outside persons. Information about students and family is strictly confidential.
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