CANCER MANAGEMENT PLAN

School Year: _____

STUDENT NAME:	**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 snacks/water as needed
- Avoid sources of potential infections
- Administer medications as provided by parent
- Limit sun exposure; use sunscreen as provided by parent
- OTHER:_____

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.

School Clinic: Copy of this plan to be provided to Transportation Supervisor

_____ _____

PARENT SIGNATURE/DATE COUNTY SCHOOL NURSE SIGNATURE/DATE

Information about students and family is strictly confidential.

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