STUDENTS

Management of Students with Cancer in the School Setting

These are guidelines to follow when the school/School Age Child Care (SACC) is informed of the presence of a student with a cancer diagnosis.

I. Modern advanced technologies allow the students with cancer to attend school/SACC. Prince William County Public Schools (PWCS)/SACC, with parental permission and medical guidance from the Cancer Care Plan will:

A. Focus on maintaining wellness and normalcy of the academic and social aspects of the student’s transition back to school.

B. Address medical management of the student while at school/SACC.

II. To properly care for a student diagnosed with cancer in the school setting/SACC the following must occur:

A. A Cancer Care Plan must be completed yearly by a licensed health care provider (see Attachment I).

B. At least three school staff/child care contractors (CCC) members shall be trained on the specifics of the student’s Cancer Care Plan.

C. A Medication Authorization form must be completed by the health care provider and signed by the parent/guardian prior to staff/CCC administering medications. Refer to Regulation 757-4, “Administering Medication.”

D. Students with a Cancer Care Plan are not required to have a Health Treatment Procedure or Emergency Treatment Plan as described in Regulation 757-3, “Guidelines for School Staff/Child Care Contractor (CCC) to Carry Out Health Treatment Procedure and/or Emergency Treatment Procedures in the School Setting or any Prince William County Public School (PWCS) Extended Day or Overnight Field Trip,” if no medical procedure(s) (i.e., gastronomy tube feeding, suctioning, catheterizations, etc.) are required during the school day/SACC.

E. A Health Treatment Procedure or Emergency Treatment Plan as described in Regulation 757-3 is required if a medical or emergency procedure (i.e., gastronomy tube feeding, suctioning, catheterization, etc.) is or may be required during the school day/SACC.
F. This plan serves as a tool to determine the health needs of students as they return to school once diagnosed with cancer.

The Associate Superintendent for Student Learning and Accountability (or designee) is responsible for implementing and monitoring this regulation.

This regulation and related policy shall be reviewed at least every five years and revised as needed.

Cancer Care Plan
Prince William County Public Schools

Student’s Name: ___________________________  Student’s School: ___________________________

Student’s Date of Birth: ______________________  Student’s Grade: ___________________________

Names of siblings in home and schools they attend: ________________________________________

Student’s medical diagnosis: _________________________  Medical alerts: _________________________

When was cancer diagnosed and what stage? _____________________________________________ Has any metastasis been identified? □ Yes  □ No

Have there been periods of remission? □ Yes □ No  How long? _______________  Last acute episode _________

Has student had previous hospitalizations for condition? □ Yes □ No  Explain ______________________________

Has student had previous surgeries for condition?  □ Yes □ No  Explain ______________________________

Has student had chemotherapy? □ Yes □ No  When? _________________________________________

Does student currently have? □ Implanted port □ Tunneled catheter □ Other treatment device ________

List student’s chemotherapy medications: ________________________________________________
(Multiple protocols may be attached) _______________________________________________________

List any other medications: _____________________________________________________________

Are there any medications needed at school? □ Yes □ No (refer to Regulation 757- 4, “Administering Medications” Attachment I, Sections A and B)

Has student had radiation therapy? □ Yes □ No  When? ___________  Which body area? _________________

Is there any physical disability related to diagnosis or treatment? □ Yes □ No  Explain _________________________

Are there any known growth, developmental, or cognitive effects from the treatment or disease? □ Yes □ No

Explain _________________________________

Are there any specific accommodations or adjustments required in the classroom setting? □ Yes □ No

Explain _________________________________

Are there any procedures or treatments that are required while the student is in school? □ Yes □ No

Explain (If yes, please see Regulation 757-3, “Guidelines for School Staff/Child Care Contractor (CCC) to carry out Health Treatment Procedure and/or Emergency Treatment Procedures…”)

__________________________________________    _______________
Signature of Approval                                         Date
Supervisor of School Health Services
Are there cognitive effects from this treatment? □ Yes □ No

Explain ____________________________________________________________________________________________________________________________________________________

Possible side effects from the disease and/or therapy:

☐ hair thinning/loss ☐ mouth sores ☐ increased fatigue
☐ weight gain/increased appetite ☐ weight loss ☐ nausea/vomiting
☐ mood swings ☐ increased chance of bleeding (gums, nose, bruises) ☐ increased chance of infection
☐ other _______________________________________________________________________________

Limitations on activity:

☐ no limitations – unless parents advise you otherwise ☐ no contact sports ☐ activity as tolerated
☐ crutches ☐ wheelchair

Emergency Management of Student - Please contact parents for the following:

Temperature of 100° or greater.
Coughing that does not stop or rapid breathing.
Pain with urination or bowel movements.
Exposure to chicken pox, shingles, measles, or other contagious illnesses.
Headache unrelieved by Tylenol. (Always check temperature before giving Tylenol. Do not give Ibuprofen products.)
Complains of problems with vision, hearing, or balance.
Nosebleed that does not stop after 10 minutes of pinching both nostrils shut.
Blow to the head or catheter site.
Leakage or break in the catheter. (If catheter breaks, place clamp between body and break.) Clamp stored in ____________.

Activity Guidelines for the student with cancer (students should be encouraged to participate in physical activity):

Expect the student to dress out.
Allow the student to pace him or herself.
Allow frequent rest and water breaks.
The student should not participate in extended strenuous exercise in hot weather.
Student with a low platelet count should be exempt from PE until platelet count recovers.
Students should avoid close contact with classmates who are sick.
If student has an implanted port, activities such as football, wrestling, and work on the parallel bars should be avoided.
If the student has a tunneled catheter or PICC line, contact and stick sports should be avoided. Swimming should also be avoided.
Parents must be notified IMMEDIATELY for any bleeding that lasts longer than 10 minutes with pressure.

Anticipated school absences:

☐ minimal (less than 5 days per month) ☐ moderate (5-10 days per month) ☐ significant (greater than 10 days per month)

Comments: _______________________________________________________________________________________________
IMPORTANT CONSIDERATIONS

1. Notify parents if student has any acute illness, fever, or change in condition or behavior.

2. NO LIVE VIRUS VACCINATIONS OR IMMUNIZATIONS (i.e., varicella, MMR) should be given to a child receiving chemotherapy.

3. Report any incidences of measles, chicken pox, or shingles in the school to parents IMMEDIATELY.

Physician’s Name: _________________________________ Phone Number: __________________________
Physician’s Address: _________________________________ Fax Number: __________________________
Physician’s Signature: _________________________________ Date: __________________________

I agree to the implementation of this Health Treatment Plan for my child. I give permission for the school health professional to communicate with the health care provider regarding this Cancer Care Plan.

Parent Signature: _________________________________ Date: __________________________
Parent Emergency Contact Phone Numbers: ______________________________________________

Designated School Case Manager: Name____________________________ Phone Number______________________________

The staff signatures below indicate receipt of information/training regarding this student’s Health Treatment Plan:

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<th>Printed Name</th>
<th>Signature</th>
<th>Trainer’s Signature</th>
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