IHP/EAP for Student with Cancer

Name _____Date of Birth:_____
Parent/Guardian_____
Phone (w)_____(h)_____(cell)_____
Physician_____Phone_____

Medical History/Diagnosis:

_____
_____
_____

Please list any limitations - Physical, Cognitive, etc

_____
_____
_____

Medications/Chemotherapy:

_____
_____
_____

Call parents if:

- ☐ Temperature of greater than_____
- ☐ Other _____
  _____
  _____

Call 911 if:

_____
_____
_____

SPECIAL INSTRUCTIONS/COMMENTS

_____
_____
_____

Physician Consent for Cancer IHP

I have reviewed and approved this IHP and included any recommended modifications. This consent is for a maximum of one year. If changes in procedure are indicated, I will provide written orders accordingly.

_____

Physician's Signature **Date**

Parent Consent for Cancer IHP

I, as parent/guardian, concur with the above management plan, will provide the necessary supplies and equipment, notify the school nurse if there is any change in my child's health status or doctor's orders, and authorize the school nurse to contact the physician when necessary.

_____

Parent's Signature **Date**