GENERAL Medical Action Plan (MAP)

Student's Name____

Date of birth______________ **Age**_____ **Grade**_____

Child's picture; face only

Page two of this MAP is to be signed and dated by both the treating physician/licensed health care provider & by a parent/guardian. Without both signatures this MAP is not valid. All medical supplies are to be provided by the family. If medication is needed for this Medical Action Plan, **Form A** (Permission for Prescribed Medication) must be completed for each individual medicine used in this treatment MAP.

CONTACT INFORMATION

Call First(Parent/Guardian)	**Try Second(Parent/Guardian**
Name:	**Name:**
Relationship:	**Relationship:**
Home:	**Home:**
Cell:	**Cell:**
Work:	**Work:**

Call Third (If a parent/guardian cannot be reached)

Name:____Relationship:________________________________

Address:____

Phone:____

DIAGNOSIS:

SIGNS AND SYMPTOMS:

1.
2.
3.
4.
5.

IF SYMPTOMS OCCUR, DO THE FOLLOWING:

ADDITIONAL NOTES/INSTRUCTION:

If medication is to be used at school for the above condition, **Form A** "Permission for Prescribed Medication" will need to be completed, signed and dated by the physician/licensed prescriber AND a parent/guardian.

Physician name________________________________**Phone**________________**Fax**___________________________

(Or treating health care professional)

SIGNATURE____**DATE**____________________

I agree with this plan as written and for school staff to share this information with those that need to know. I give permission to use my child's picture on this plan (if I did not supply a photo) and for staff to contact the treating health care professional for clarification of this plan, if needed.

Parent/Guardian name____

SIGNATURE____**Date**____________________