**School** 

## Oxford Community Schools **General Medical Action Plan (MAP)**

Student	's Name
Date of	birth
Age	Grade

School Year\_\_\_\_

Child's picture

Page two of this MAP is to be signed and dated by the treating physician or licensed health care provider & by a parent/guardian. Without signatures this MAP is not valid. All medical supplies are to be provided by the family.

## **CONTACT INFORMATION**

	<u>Call First</u>	Try Second
Parent/	Name:	Name:
Guardian:	Relationship:	Relationship:
Phone:	Home:	Home:
	Cell:	Cell:
	Work:	Work:
Call Third (I Name:	f a parent/guardian cannot be reached)	Relationship:
Address:		Phone:

## **DIAGNOSIS**

## SIGNS & SYMPTOMS

1.

2.

3.

Revised May 2011 Page 1 of 2

Transportation Office Use ONLY if needed

Bus # Driver: Route # Medical File

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 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to us 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  PARENT SIGNATURE Date	Student Name		Page 2 of 2
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 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to us 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	IF SYMPTOMS OCCUR, DO THE FOLLOWING	3	
f 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  agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to us 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			
f 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)  IGNATURE Date  agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to us ny child's picture on this plan (if I did not supply a photo) and for staff to contact the treating health care professional for larification of this plan, if needed.  Parent/Guardian name			
f 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)  IGNATURE Date  agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to us ny child's picture on this plan (if I did not supply a photo) and for staff to contact the treating health care professional for larification of this plan, if needed.  Parent/Guardian name			
f 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)  IGNATURE Date  agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to us ny child's picture on this plan (if I did not supply a photo) and for staff to contact the treating health care professional for larification of this plan, if needed.  Parent/Guardian name			
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  Tagree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to us 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 starification of this plan, if needed.  Parent/Guardian name			
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  If agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to us 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			
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  If agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to us 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			
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  Tagree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to us 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 starification of this plan, if needed.  Parent/Guardian name			
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  If agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to us 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			
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  If agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to us 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			
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 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to us 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			
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  If agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to us 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			
Physician name Phone Fax  Or treating health care professional)  SIGNATURE Date  agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to using 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	ADDITIONAL NOTES / INSTRUCTIONS		
Physician name Phone Fax  Or treating health care professional)  SIGNATURE Date  agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to us 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			
Physician name Physician name Physician phealth care professional)  SIGNATURE  Date  I agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to using 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			
Physician name Physician name Physician phealth care professional)  SIGNATURE  Date  I agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to using 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			
Physician name Phone Phone Phone Fax  (Or treating health care professional)  SIGNATURE Date  I agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to using 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			
Physician name Phone Fax  Or treating health care professional)  SIGNATURE Date  I agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to us 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			
Physician name Physician name Phone Physician name Phone Pho			
Physician name Phone Fax  Or treating health care professional)  SIGNATURE Date  I agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to us 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			
I agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to using 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			
I agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to using 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	Dhysiojan nama	Dhono	Fov
I agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. 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	Or treating health care professional)	I none	I da
understand that my child's name may appear on a list with other students having emergency needs. I give permission to us 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
anderstand that my child's name may appear on a list with other students having emergency needs. I give permission to us 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 larification of this plan, if needed.  Parent/Guardian name			
	understand that my child's name may appear on a list with only child's picture on this plan (if I did not supply a photo) a	other students having	emergency needs. I give permission to us
PARENT SIGNATUREDate			
	Parent/Guardian name		