

Traders Point Christian Schools

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 _____