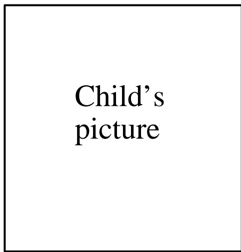
Student Name____ Attachment A

Oxford Community Schools
General Medical Action Plan (MAP)

Student's Name ______________________________
Date of birth _________ **School** ______________________
Age _____ **Grade**_______ **School Year**_______________



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.

Transportation Office Use ONLY if needed
Bus # Driver:
Route #
Medical File

CONTACT INFORMATION

Parent/ Guardian: Phone:	**Call First**	**Try Second**
	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 & SYMPTOMS

1.

2.

3.

IF SYMPTOMS OCCUR, DO THE FOLLOWING

ADDITIONAL NOTES / INSTRUCTIONS

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 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 ____

PARENT SIGNATURE ____ **Date** _________