Cherokee County School District

INTERMITTENT CATHETERIZATION ACTION PLAN

STUDENT_____ D.O.B._____

SCHOOL_____ TEACHER_____

HOME PHONE_____ GRADE_____

MOTHER / LEGAL GUARDIAN_____

PHONE (CELL)_____ (WORK)_____

FATHER / LEGAL GUARDIAN_____

PHONE (CELL)_____ (WORK)_____

Diagnosis_____

Medications_____

_____

Catheterization Times (Parent will provide supplies/ equipment)

@ Home_____

@ School_____

Is student performing self-cath.?_____

Needs assistance with?_____

_____

Does student have a shunt?_____

When was the shunt put in?_____

Signs and symptoms of shunt malfunction_____

_____

I, _____, authorize the physician's office to release confidential information about my child.

_____ _____

Parent / Legal Guardian's Signature Date

_____ _____

Physician's Signature Date

_____ _____

Physician's Printed Name Physician's Phone Number