School Year 20__ *Confidential*

TROY SCHOOL DISTRICT
GENERAL Medical Action Plan (MAP)

Child's picture
Face only

Student's Name: School:
Date of Birth: Age:
Grade: Teacher**:**

This MAP is validated with signatures and dates, by both the treating physician/licensed health care provider & parent/guardian. Orders are required for medical interventions within this treatment plan. Expiration of this plan occurs at the end of the current school year.

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

CONTACT INFORMATION

Call First:	Call Second:	Call Third:
Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
Phone 1:	Phone 1:	Phone 1:
Phone 2:	Phone 2:	Phone 2:
Email:	Email:	Email:

Medical Diagnosis/Conditions:

Signs and Symptoms:

ACTIONS

IF THESE SYMPTOMS/CONDITIONS OCCUR:	**PERFORM THIS ACTION:**

EMERGENCY PROCEDURES

ADDITIONAL SAFETY INSTRUCTIONS

1. If medication is needed during school hours for the above medical condition(s), **the School Medication Administration Authorization form** must be completed for each individual medication used in this treatment plan. Physician/licensed health care provider orders are required for ALL prescription and non-prescription medications.

2. Please provide orders for any durable medical equipment needed and specific instructions for daily use:

Licensed Health Care Provider's Name:
Hospital and/or Clinic Name:
Street Address:
Suite:
City/State/Zip Code:
Phone Number:
Fax Number:

(Provider Stamp)

HEALTH CARE PROVIDER SIGNATURE: _____ Date: _____

I, (parent/guardian), _____, request that my child, _____, receive the above described medical management at school, according to standard school policy, I authorize consent to the ordering licensed health care provider staff and school to share information, as needed, to clarify orders and to assist with my child's health care needs. I agree to have the information, in this two page plan, shared with individuals that need to know. I also, give permission to use my child's picture on this plan (if I did not supply a photo).

PARENT/GUARDIAN SIGNATURE: _____ Date: _____