ROCHESTER COMMUNITY SCHOOLS
PRIDE IN EXCELLENCE

Child's picture
Face only

ROCHESTER COMMUNITY SCHOOLS
URINARY CATHETERIZATION Medical Action Plan (MAP)

Student's Name: ____________________ School: ___________________________
Date of birth: ______________________ Age: ______
Grade: ____________________________ Teacher: __________________________

This MAP is validated with signatures and dates, by both the licensed health care provider (Doctor of Osteopathic Medicine, D.O., Medical Doctor, M.D., Nurse Practitioner, N.P., or Physician Assistant, P.A.), and a parent/legal guardian. Recommended orders for medical interventions within this treatment plan, will expire at the end of the 2024-2025 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 Condition (s): ____

____

ACTIONS

Catheter Type:	Catheter Size:	Catheter Technique:	Catheter Schedule:	Catheter Supplies:
☐ Straight ☐ Indwelling ☐ Suprapubic ☐ Other: __________ __________ __________ __________ __________	☐ ______French ☐ Other: __________ __________ __________ __________ __________ __________	☐ Clean ☐ Sterile ☐ Other: __________ __________ __________ __________ __________ __________	☐ Every _______hours ☐ Other: __________ __________ __________ __________ __________ __________ __________	☐ Catheter(s) ☐ Non-Sterile gloves ☐ Lubricant ☐ Urinal ☐ Catheter cap ☐ Iodine swabs OR ☐ Antiseptic (other) ☐ Other: ___________ __________ __________ __________

Revised Mar 2024

IF THESE SYMPTOMS/CONDITIONS OCCUR:	PERFORM THIS ACTION:
1.Monitor for signs/symptoms of infection and/or	1.Call parent or emergency contact.
inability to perform catheterization.	
2.Other (as applicable):	2.Other:

AUTHORIZED LICENSED HEALTH CARE PROVIDER ORDERS AND AGREEMENT WITH TREATMENT PLAN

☐ YES ☐ NO Student is independent and may perform self-care.

☐ YES ☐ NO Student may need assistance; please provide instructions: ____________________

____

____

Provider's Name: ______________________________ Hospital and/or Clinic Name: __________________________

Street Address: ____ Suite: __________________

City: ____ State: ______________ Zip Code: _______________

Phone Number: ________________________________ Fax Number: ____

HEALTH CARE PROVIDER SIGNATURE: _______________________________________ Date: ______________

PARENT/GUARDIAN CONSENT

I, (parent/guardian), ______________________________, request that my child, ________________________________, receive the attached 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 entire plan, shared with individuals that need to know. Also, I give permission to use my child's picture on this plan (if I did not supply a photo).

PARENT/GUARDIAN SIGNATURE: ____ Date: ________________