

Child's picture
Face only

URINARY CATHETERIZATION Medical Action Plan (MAP)

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 2025-2026 school year.

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:
<input type="checkbox"/> Straight <input type="checkbox"/> Indwelling <input type="checkbox"/> Suprapubic <input type="checkbox"/> Other: _____ _____ _____ _____ _____ _____	<input type="checkbox"/> _____ French <input type="checkbox"/> Other: _____ _____ _____ _____ _____ _____	<input type="checkbox"/> Clean <input type="checkbox"/> Sterile <input type="checkbox"/> Other: _____ _____ _____ _____ _____ _____	<input type="checkbox"/> Every _____ hours <input type="checkbox"/> Other: _____ _____ _____ _____ _____ _____	<input type="checkbox"/> Catheter(s) <input type="checkbox"/> Non-Sterile gloves <input type="checkbox"/> Lubricant <input type="checkbox"/> Urinal <input type="checkbox"/> Catheter cap <input type="checkbox"/> Iodine swabs OR <input type="checkbox"/> Antiseptic (other) <input type="checkbox"/> Other: _____ _____ _____ _____

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

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: _____