

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 2026-2027 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:
☐ 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: _____ _____ _____ _____

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: _____