Oxford Community Schools
General Medical Action Plan (MAP)

Student's Name _____
Date of birth _____ **School** _____
Age _____ **Grade**_____ **School Year**_____

Child's picture

Page two of this MAP is to be signed and dated by the treating physician or licensed health care provider & by a parent/guardian. Without signatures this MAP is not valid. All medical supplies are to be provided by the family.

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

CONTACT INFORMATION

		Call First	**Try Second**
Parent/ Guardian:	Name:	_____	Name: _____
	Relationship:	_____	Relationship: _____
Phone:	Home:	_____	Home: _____
	Cell:	_____	Cell: _____
	Work:	_____	Work: _____

Call Third (If a parent/guardian cannot be reached)
Name: _____ Relationship: _____
Address: _____ Phone: _____

DIAGNOSIS

SIGNS & SYMPTOMS

1.

2.

3.

IF SYMPTOMS OCCUR, DO THE FOLLOWING

ADDITIONAL NOTES / INSTRUCTIONS

If medication is to be used at school for the above condition, **Form A "**Permission for Prescribed Medication" will need to be completed, signed and dated by the physician/licensed prescriber AND a parent/guardian.

Physician name _____ **Phone** _____ **Fax** _____
(Or treating health care professional)

SIGNATURE _____ **Date** _____

I agree with this 2 page plan as written and for school staff to share this information with those that need to know. I understand that my child's name may appear on a list with other students having emergency needs. I give permission to use my child's picture on this plan (if I did not supply a photo) and for staff to contact the treating health care professional for clarification of this plan, if needed.

Parent/Guardian name _____

PARENT SIGNATURE _____ **Date** _____