

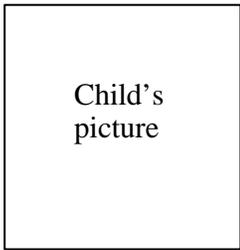


**Oxford Community Schools**  
**General Medical Action Plan (MAP)**

**Student's Name** \_\_\_\_\_

**Date of birth** \_\_\_\_\_ **School** \_\_\_\_\_

**Age** \_\_\_\_\_ **Grade** \_\_\_\_\_ **School Year** \_\_\_\_\_



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.

**CONTACT INFORMATION**

	<b><u>Call First</u></b>	<b><u>Try Second</u></b>
Parent/	Name: _____	Name: _____
Guardian:	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.

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

**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** \_\_\_\_\_