Student Name _____

Student's photo

Renaissance Academy Medical/Mental Health Action Plan (MAP)

Date of Birth_____
Age_____**Grade**_____ **School Year** _____

Page one of this MAP is to be completed, signed, and dated by a parent/guardian.
Page two of this MAP is to be completed, signed, and dated by the treating physician or licensed prescriber.
Without signatures this MAP is not valid.
The parent/guardian is responsible for supplying all medications, medication release form, and any otherneeded equipment/supplies to Renaissance Academy (RA).

CONTACT INFORMATION

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

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

MEDICAL HISTORY

Please describe the medical/mental health issue

I agree to have the information in this two page plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having medical/mental health concerns to better identify needs in an emergency. I give permission to use my child's picture on this plan (if I did not supply a photo.) I give permission for trained staff to help administer medicationordered and to contact the physician/licensed prescriber for clarification of orders, if needed.

Date_____Parent/Guardian_____
Signature

Signs to watch for

Action

Signs of EMERGENCY

Action

Authorized Physician/Licensed Prescriber Order & Agreement with Protocol in this 2 page plan

Medication_____Route Dose _____

Other instructions/orders_____

Physician/Licensed Prescriber Name_____

Phone number_____ **FAX number**_____

Signature_____ **Date**_____