East Martin Christian School
516 118th Avenue
Martin, MI 49070
Phone: 269-672-5722
Fax: 269-672-5736

East Martin Christian School
Medical Action Plan (MAP)

Reason For Request:_____

Note: Medication will not be dispensed until this form is completed by a medical professional.

Child's Name:		Date of Birth:	
Provider's Name:		Clinic Name:	
Address:		City:	
State:		Zip:	Phone #:

To be completed by Health Care Professional:

Condition:		**Diagnosed by:**		**Date:**	
Symptoms:					
Medication:	☐ **Will** ☐ **Will not** **be administered at East Martin Christian School.**				

Medication must meet the following criteria to be distributed at school:

1. The Medication must be in the original prescription container with the label adhered.
2. A specific time is mandated to dispense medication (i.e. at 2 p.m., after all meals, before a meal).
3. Pharmacy's name, physician's name, child's name, dosages and instructions, name and strength of medication, date of refill/prescription (must be current) is on label.
4. This form must be renewed if the prescription is changed in any way.

Medication(s) Name:_____
Administration Instructions: Frequency: _____ **Quantity:** _____
Start Date: ____/____/____ **End Date:** ____/____/___
Storage Instructions: _____
Special Equipment:_____
Instructions: _____

School Restrictions:	**Physical Activity** ☐ **No/** ☐ **Yes:** _____ **Other:**_____ **Diet:** ☐ **No/** ☐ **Yes** _____

Call Parent If:	**Call 911 If:**	**While Waiting for Help:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of Physician / Date	**Signature of Parent (Guardian) / Date**
_____ ___/___/___	_____ ___/___/___

EMCS Staff		
Staff Members:	**Signature**	**Date**
Teacher		____/____/____
Principal		____/____/____
		____/____/____
		____/____/____
		____/____/____
		____/____/____
		____/____/____