



INTERMITTENT CATHETERIZATION ACTION PLAN

STUDENT _____ D.O.B. _____

SCHOOL _____ TEACHER _____

HOME PHONE _____ GRADE _____

MOTHER / LEGAL GUARDIAN _____

PHONE (CELL) _____ (WORK) _____

FATHER / LEGAL GUARDIAN _____

PHONE (CELL) _____ (WORK) _____

Diagnosis _____

Medications _____

Catheterization Times @ Home _____

(Parent will provide supplies/
equipment)

@ School _____

Is student performing self-cath.? _____

Needs assistance with? _____

Does student have a shunt? _____

When was the shunt put in? _____

Signs and symptoms of shunt malfunction _____

I, _____, authorize the physician's office to release confidential information about my child.

Parent / Legal Guardian's Signature

Date

Physician's Signature

Date

Physician's Printed Name

Physician's Phone Number