Individualized Health Care Plan   **Student Name:**   **School Year:**

ADD / ADHD Individualized Healthcare Plan

SECTION I			
Student:			WT:
			HT:
Grade:	D.O.B	Any Known Allergies	
School:			
District:		Bus (check one) ☐YES ☐NO	
		Bus #AM	Bus #PM
School Nurse:		Phone #	Cell #
Medication taken at home: (please list)			

Contacts

Mother	Home #	Work #	Cell #
Father	Home #	Work #	Cell #
Guardian/Custodian	Home #	Work #	Cell #
Home Address		City #	Zip
Emergency Contact (Relationship)		Home #	Work #
Physician		Phone #	Fax#
Physician Address		City	Zip

Date	Special Notes

Individualized Health Care Plan   **Student Name:**   **School Year:**

ADD / ADHD Individualized Healthcare Plan

SECTION II: EMERGENCY ACTION PLAN (Directions for those who have a" need to know")	
IF YOU SEE THIS…	DO THIS…
Unusual loss of appetite	Notify School Nurse
Complaint/Report of fast heart rate	Notify School Nurse
Unusual restlessness	Notify School Nurse
Report of unusual insomnia	Notify School Nurse
Encourage ventilation of feeling	Provide support and advocate for student, as needed
Refocus attention as needed	Provide support and advocate for student as needed

Is a PRESCRIBER/PARENT AUTHORIZATION (PPA) on file for this student? □ No   □ Yes

* PRESCRIBER/PARENT AUTHORIZATION (PPA) is required for all medication given at school

School Nurse Use Only

*Medication	Expiration Date	Location of Medication

Notes /Special Instruction_____

_____

Individualized Health Care Plan   Student Name: School Year:

ADD / ADHD Individualized Healthcare Plan

SECTION III:

Brief description of medical condition: ADD / ADHD is a disorder that presents with little impulse control, short attention span, and immature control of small muscles. The student with ADD/ADHD rarely finishes anything and is very active. If left untreated, the disorder can have long term effects on a child's ability to make friends or do well at school or work.

Avoid circumstances that may lead to potential emergency:

SCHOOL DAY:	PHYSICAL EDUCATION:
□ Ensure student takes medication at appropriate times. □ Give medication as ordered Verify 7 rights of administration □ Monitor behavior and assist in using stress management to reduce frustrations. □ Monitor student for side effects of medication. □Send student to nurse as needed	Restrictions for Physical Education □ No □ Yes If yes, please specify:
FIELD TRIPS:	**BUS TRANSPORTATION:**

Requires assistance:
    □ Unlicensed Medication Assistant
    □ Nurse, if indicated
    □ None
    □ Parent/Guardian attending
Specify:
	Special arrangements
	□ No
	□ Yes
	If yes, please specify:

EMERGENCY DRILLS AND SCHOOL CRISIS EVENTS	**OTHER:**
□ During Crisis Event Follow School Safety Plan. □ In event of building evacuation, School Nurse or Medication Assistant will evacuate with medications**.**	After School Care:
□ In event of building evacuation, School Nurse Location is: □ Student requires assistance to evacuate building? □ No □ Yes, describe _____	Extracurricular Activity:

Individualized Health Care Plan   **Student Name:**   **School Year:**

Written Notes/Addendum to Plan of Care

DATE		PARENT/ GUARDIAN INTIALS (if needed)

I understand and agree with this Individualized Healthcare Plan.
I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency.
I give permission for the release of my child's medical information, in the event of an emergency.

_____   _____
Signature of Parent or Guardian   **Date**

_____   _____
Signature of School Nurse   **Date**

Individualized Health Care Plan   **Student Name:**   **School Year:**

Communication of the Individualized Health Care Plan

SECTION IV:

☐ Check this Box if Read Receipt is used to communicate Individualized Health Care Plan to staff.

    * Nurse to attach Read Receipt document to this packet.

☐ Check this box if staff receives and signs below for Individualized Health Care Plan.

I have read and understand this student's Individualized Healthcare Plan, and have printed a copy to be maintained in my confidential folder/binder of instructions for substitute teachers.

I have been given the opportunity to ask questions.

I understand my role in addressing this students medical needs.

I am aware the school nurse is available to help clarify any future concerns.

Employee Name	Employee Signature	Position Held	Date