HARVESTCHRISTIANACADEMY ADD/ADHD CARE PLAN



Student Name:		DOB:	_ Today's Date:
Age at Diagnosis:	Combined	Inattentive	Hyperactive
Parent(s) Name:			_ Phone:
Physician Name:			Phone:

_____Student has been diagnosed but parent requests no accommodation at school

_____Student has been diagnosed and parent requests doctor recommendations be followed while at school.

To be filled out by the doctor:

Inattention Symptoms: (circle or check)			
Dislikes tasks that take focus for a long time	Difficulty keeping attention on task or play	Trouble organizing tasks	Rarely finishes tasks
Does not follow through on instructions with schoolwork, chores	Difficulty with close attention to details	Easily distracted	Difficulty sitting still
Looses things necessary for tasks	Does not seem to listen when spoken to directly	Forgetful in daily activities	

Hyperactive Symptoms: (circle or check)				
Fidgets with or taps hands or feet, or squirms in seat.	Often leaves seat in situations when remaining seated is expected.	Often runs about or climbs in situations where it is not appropriate	Often unable to play or take part in leisure activities quietly.	Often interrupts or intrudes on others
Is often "on the go" acting as if "driven by a motor".	Often blurts out an answer before a question has been completed.	Often has trouble waiting his/her turn.	Often talks excessively.	

MEDICATIONS AND SIDE EFFECTS

Home Medication Name:	Dose <u>:</u>		
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Possible side effects seen in the classroom (Circle or Check)*				
Growth retardation	Stomachache	Muscle tics	Over Stimulation	
Constipation	Vomiting	Vocal tics	Depression	
Diarrhea	Sinusitis	Agitation	Irritability	
Dry Mouth	Sore Throat		Anxiety	
Loss of appetite	Headache	Dizziness	Restlessness	Fast heart rate
Weight loss	Abdominal pain	Tremors	Insomnia	Heart Palpitations

*If any of the above symptoms are noted, teacher or nurse will notify the parent.

PHYSICIAN RECOMMENDATIONS FOR SCHOOL

Physician Signature		Date	
EDICATION AUTHORIZATIONS			
	_		
may take			
	Medication name	dose	frequency
Physician's signature:			

- I assume responsibility for supplying medication to the school that will not expire during the course of its intended use. *Expired medication cannot be administered.*
- I understand that medication must be in its original container.
- I request this medication be administered as ordered by the students' licensed health care provider.
- I understand that this medical information may be shared with school staff working with my child.

Parent's signature:	
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This form adapted from Centers for Disease Control and Prevention website on ADD diagnosis.