



Our mission is to develop children who are confident and creative learners. We provide a rigorous curriculum and a supportive school environment that promotes high achievement, encourages personal growth, and meets the unique needs of each child.

STUDENT SERVICES DEPARTMENT

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EMERGENCY HEALTH CARE PLAN – ATTENTION DEFICIT/HYPERACTIVITY DISORDER

Effective School Year: 20 to 20 Today's Date:

Student's Name: Date of Birth: Grade:

Physician's name and phone #:

Parent/Guardian #1 name and #:

Parent/Guardian #2 name and #:

ATTENTION DEFICIT/HYPERACTIVITY DISORDER

Description: Implicated in learning disorders and one criteria is demonstrating several inattention, and/or hyperactivity/impulsivity symptoms.

IF YOU SEE THIS:

- Inattention: careless mistakes or poor attention to detail, poor organization, poor sustained attention, does not follow through or fails to finish tasks, does not seem to listen when spoken to, loses objects, easily distracted, forgetful in daily activities, avoids tasks requiring effort
Hyperactivity/impulsivity: fidgets, leaves seat, runs or climbs excessively, difficulty playing quietly, always "on the go," talks excessively, blurts out answers, can't wait turn, interrupts others.

DO THIS:

- reinforce any behavioral management goals
2. medication as ordered by the physician
3. observe for possible medication side effects: lack of appetite, nausea, stomachache, headache, insomnia, weight loss, may exacerbate tics or tourette's syndrome, increased anxiety/nervous habits, mood lability or irritability, apathy or the "zombie effect," increased heart rate, increased blood pressure.

TO BE REVIEWED AND SIGNED BY PARENT/GUARDIAN

I give permission to the school nurse/health clerk and other designated staff members of District 68 to perform and carry out the emergency care plan as outlined by this emergency health care plan. I also consent to the release of the information contained in this emergency health care plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Parent Signature

Date

TO BE COMPLETED BY PHYSICIAN OR LICENSED PRESCRIBER UPON REVIEW AND APPROVAL

Medications student takes at home:

Medication to be taken at school for this condition:

Physician signature

Date

This form shall be effective for the current school year only, and must be renewed each subsequent school year.