EAGLE COUNTY SCHOOLS

Eagle County School District
Individualized Health Plan
ADHD/ADD
Effective Date: _____

Picture

Student		DOB		Home Phone	
Mother		Work Phone		Cell Phone	
Father		Work Phone		Cell Phone	
Guardian			Phone		
School Nurse			Phone		
School		Grade	Teacher		
Primary Physician		Phone		Fax	
Specialist		Phone		504 Plan/IEP	☐ Yes ☐ No
Hospital of Choice			Date of Diagnosis		
Medical Diagnosis					
Medications				Allergies	

A neurobehavioral disorder or a developmental disability in childhood can profoundly affect the academic achievement, well-being and social interactions of children.

Nursing Diagnosis/ Concerns	Educational Goal	Plan of Action
1. Potential for impaired educational, social and coping skills related to _____.	1. Student will increase optimum participation in educational program 2. Student will demonstrate successful coping patterns.	1. Student will be given information and health counseling related to _____ at the student's level of understanding. 2. Family, teachers and other staff will be provided information, consultation and support as it relates to student's needs. 3 Set clear limits for the student, be consistent in enforcing the limits and reward good behavior.
2. Potential Adverse Side effects of Medication:_____	Student will follow medical treatment plan during the school day.	1. Student will come to the health office for supervised administration of the following medication(s). Medication _____ Dose _____ Time_____ Medication _____ Dose _____ Time _____ 2. If student has not come within 30 minutes of time medication is due, student will be reminded to come down to the health office. Parent will be notified if occurrence happens more than 3 times a month. 3. Parent will be notified if medication is not given at school and when a field trip is planned away from school. 4. Student is taking the following medication at home: Medication_____ Dose_____Time_____ 5. The school nurse/ health assistant will consult with parents and/or make a referral so that appropriate medical follow-up can occur if there are concerns related to the medication. 6. School personnel will cooperate with health care provider to complete check lists, classroom observations or provide data as needed to determine need or therapeutic benefit of medication and other intervention(s). 7. Notify parents if side effects are observed. Possible side effects: Headache, restlessness, dizziness, insomnia, depression, tremor, headache, exacerbation of nausea/vomiting, diarrhea, dryness of the mouth, weight loss.

Revised 2-2015 B-01

As parent/guardian of the student I give permission for this plan to be available for use in my child's school. The plan will be reviewed on a yearly basis or when there is a change in the student's condition. The parent's signature indicates permission to contact the above mentioned health care provider(s) as needed. I also understand that this information may be shared with necessary school personnel on a need-to-know basis to help ensure this child's safety and well-being while at school or during school related activities.

Physician Signature:_____ Date: _____

Parent Signature: _____ Date:_____

Nurse Signature: _____ Date: _____