Christian Liberty Academy
502 W. Euclid Avenue, Arlington Heights, Illinois 60004
(847) 259-4444 FAX# (847) 385-2062

ADD / ADHD CARE PLAN

STUDENT NAME: _____D.O.B._____GRADE: _____

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 physician:

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	

To be filled out by the physician:

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.	

To be filled out by the physician:

MEDICATIONS AND SIDE EFFECTS:

Home Medication Name: _____Dose:_____
Home Medication Name: _____Dose:_____

Possible side effects seen in the classroom from home medications (Circle or Check)*				
Growth retardation	Stomachache	Muscle tics	Muscle tics	Fast heart rate
Constipation	Vomiting	Vocal tics	Depression	Heart Palpitations
Diarrhea	Sinusitis	Agitation	Irritability	
Dry Mouth	Sore Throat		Anxiety	
Loss of appetite	Headache	Dizziness	Restlessness	
Weight loss	Abdominal pain	Tremors	Insomnia	

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

Page 2: ADD/ADHD Care Plan for: _____ (name of student)

PHYSICIAN RECOMMENDATIONS FOR SCHOOL

_____
_____
_____
_____

MEDICATION AUTHORIZATIONS

Name of Medication:_____

Dose:_____Route:_____

Time(s) to be given: _____

List any side effects this child might experience as a result of the medication:

_____
_____
_____

List any restrictions of activity or special needs for assistance:

_____

_____ _____
Signature of Health Care Provider with Prescriptive Authority License Number of Health Care Provider

_____ _____
Printed Name of Health Care Provider Phone Number

Dated: _____

Parent Must complete and sign this section:

- 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.

I give permission for this information to be shared with adults at Christian Liberty Academy on a need to know basis. *This health care plan will be in effect for the current school year. I understand that it is my responsibility to notify the Nurse's Office whenever there is a change in my child's health status or care.*

_____ Dated: _____
Parent/Guardian Signature