

**Washington Elementary School**  
**Attention Deficit Disorder/ Hyperactive Disorder**  
**Teacher/Student Health care Plan**

Student's Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Grade \_\_\_\_\_ Sex: Male: \_\_\_\_\_ Female: \_\_\_\_\_ Teacher: \_\_\_\_\_

Emergency Contacts and Phone Numbers: Physician Name: \_\_\_\_\_  
Stamp: \_\_\_\_\_  
Name: \_\_\_\_\_  
Tel. #: \_\_\_\_\_ Tel. # \_\_\_\_\_

---

**I Diagnosis:** Attention Deficit/ hyperactive Disorder

**II. Description:** Implicated in learning, disorder is an excessive physical activity;  
developmentally inappropriate inattention

**III. Signs & Symptoms:** Over activity, restless, jitteriness, short attentions span, poor impulse control. Has low ability to finish task, easy distracted, lack of attention, acts before thinking, has problems organizing work.

**IV. Medication:**

---

**V. Physical, Mental & Social Handicaps:** (Low self-esteem.)

---

**VI. Intervention:** Don't make student sit for long periods at a time, don't try to suppress over activity by scolding or punishment. USE ALL THEIR FIVE SENSES FOR LEARNING, OFTEN ONE SENSE FAVOR OVER THE OTHERS.

**VII. Special Health Requirements:**

Administration of medication regularly, Observe for adverse reaction from medication such as lethargy, drowsiness, insomnia, palpitation and other cardiac related complaints.

**Additional Comments:**

---

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
School Year

---

Mrs. Virgie Chi BSN, CSN, RN

\_\_\_\_\_  
Date

Tel.# 908-851-6466

**TOWNSHIP OF UNION BOARD OF EDUCATION  
UNION, NEW JERSEY**

Pupil's Name \_\_\_\_\_ School \_\_\_\_\_

Address \_\_\_\_\_ Teacher \_\_\_\_\_

Telephone No. \_\_\_\_\_ Grade \_\_\_\_\_

Description of medication provided by physician \_\_\_\_\_

Diagnosis: \_\_\_\_\_

School nurse is instructed to administer \_\_\_\_\_ in

the following manner \_\_\_\_\_

Medication to be administered from \_\_\_\_\_ to \_\_\_\_\_

**Consideration for Field Trips:**

The above named student may skip the dose of prescribed medication on a field day trip.

The above named student may take the prescribed medication upon returning to school from a field trip.

Date \_\_\_\_\_

\_\_\_\_\_  
(Physician's Signature & Stamp Required)

The school nurse is requested to administer to \_\_\_\_\_

(Child's Name)

the medication prescribed by the above-named physician.

Signature of Parent/Guardian \_\_\_\_\_

The completion of this form is the responsibility of the parent. Upon its completion, it is to be given to the school nurse who will give the medication prescribed. This form will be filed in the office of the school nurse.

**MEDICATION MUST BE BROUGHT TO SCHOOL BY PARENT IN THE  
PRESCRIPTION CONTAINER AND HANDED TO THE NURSE.**