**Township of Union Public Schools**
**Attention Deficit/Hyperactive Disorder**
**Teacher/Student Health Care Plan**
(This is confidential Information)

Student's Name_____ Date_____
Date of Birth_____ School_____
Grade_____ Sex: Male Female Teacher_____

Emergency Contacts and Phone Numbers:

**Name:**
**Phone #:**

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**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:**

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

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VI. **Intervention:** Don't make student sit for long periods at a time, don't try to suppress over activity by scolding or punishment.

**VII. Special Health Requirements:**

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**Additional Comments:**

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_____ _____
Signature of Nurse School Year

Mrs. Virgie Chi RN, BSN, CSN
Tel. # 908-851-6466

**TOWNSHIP OF UNION BOARD OF EDUCATION**
**UNION, NJ 07083**

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.**

**For School Nurses Use Only:**

| Date Received | # of Received | Received From/Print Name | Signature | Given to/Print Name | Signature |
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# MEDICATION RECORD: ADMINISTRATION – PHYSICIAN'S ORDER

School Year: _____ School: _____

Student: _____ DOB: ___/___/___ Teacher: _____ Room: _____

| MONTHS | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
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| September | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| October | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| November | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| December | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| January | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| February | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| March | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| April | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| May | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| June | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| INIT. | NAME | INIT. | NAME |
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| ____ | _____ | ____ | _____ |
| ____ | _____ | ____ | _____ |
| ____ | _____ | ____ | _____ |