



ADD/ADHD Individualized Healthcare Plan (IHCP)

Student: _____ ID#: _____
 Grade: _____ DOB: _____ Teacher: _____
 Allergies: _____
 Student's Secondary Health Concerns: _____

Nursing Diagnosis: Knowledge Deficit Related to ADD/ADHD Disease Management & Prescribed Treatment Regimen (NANDA 00126)
 Impaired social interaction related to impulsive behavior (NANDA 00052)
Student Goal: Student Will Demonstrate Understanding of the Disease Process and Management.
 Student will display appropriate behavior.

Ratings: 1- No Knowledge, 2- Limited, 3- Moderate, 4- Substantial, 5- Extensive Knowledge, N/A- Not Applicable (Circle One)

Date: _____ Date: _____ Date: _____ Date: _____

Student Knowledge: Social Interaction Skills

Student cooperates well with others	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Student exhibits consideration	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Student uses assertive behaviors as appropriate	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Uses conflict resolution strategies	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A

Student Knowledge: Behavior Management

Student uses problem solving skills	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Student expresses feelings in an appropriate manner	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Student refrains from arguing or bargaining about established limits	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Student able to stay on task	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Student controls impulsivity	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Student keeps hand to self	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A

Student Knowledge: Medication Administration

Identification & Correct Name of Medication	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Correct Use of Prescribed Medication (Correct Dose, Time, Route)	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Able to Verbalize known therapeutic effect of the medication	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Able to Verbalize Medication Side Effects	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A

Ratings: 1- Severely Compromised, 2- Substantially, 3- Moderately, 4- Mildly, 5- Not Compromised, N/A- Not Applicable (Circle One)

RN Assessment of Student Health Status

Physical Health	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Mental Health	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
School Attendance	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Readiness to Learn	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Participation In Physical Activities	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Healthy Dietary Habits	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A

Completed by:	Completed by:	Completed by:	Completed by:
Nurse's Signature:	Nurse's Signature:	Nurse's Signature:	Nurse's Signature:

***Emergency Action Plan Available in Medication Binder, UAP & Student Checklists Completed by RN**

Additional Notes: _____



**Florida Miami Dade DOH School Health Program
Roles & Responsibilities: ADD/ADHD**

Student: _____ ID#: _____
 Grade: _____ DOB: _____ Teacher: _____
 Parent/Guardian Name(s) _____ School Year: _____

School Responsibilities/Agreements	Family Responsibilities/Agreements	Student Responsibilities/Agreements
1. ADD/ADHD Medication Kept: Circle below where applicable- Clinic Main Office Classroom Other: _____	1. Provide medication for school site. Pick up and replace any expired medication Med Name & Exp. Date: _____ Med Name & Exp. Date: _____	1. Report to clinic and take medications at appropriate time.
2. UAP to administer medications per MDCPS training: _____ _____	2. Keep school staff informed of any changes in student condition, medications and updated emergency contact information. Any change in medication regimen requires new medication forms.	2. Communicate needs as appropriate.
3. CPR certified staff: _____ _____	3. Available to accompany student on field trip and carry the ADD/ADHD medication.	
4. Substitute Teacher Instructions: <u>on Lesson Plan</u>	4. Pick up any unused medication at the end of the school year.	

Parent/Guardian Signature

Date

Principal or School Administration Designee Name

Date

School Nurse

Date