Skokie School District 68

Our mission is to develop children who are confident and creative learners. We provide a rigorous curriculum and a supportive school environment that promotes high achievement, encourages personal growth, and meets the unique needs of each child.

SPECIAL SERVICES DEPARTMENT
9310 North Kenton Avenue
Skokie, Illinois 60076-1338
Telephone: 847/568-7504
Fax: 847/568-7599
internet: www.skokie68.org
Email - ibalici@skokie68.org
Andreea Balici, Health Services Coordinator
Crissy Mombela , Director of Special Services

EMERGENCY HEALTH CARE PLAN – ATTENTION DEFICIT/HYPERACTIVITY DISORDER

Effective School Year: 20 _____ to 20_____ Today's Date:_____

Student's Name: _____ Date of Birth: _____ Grade: _____

Physician's name and phone #: _____

Parent/Guardian #1 name and #: _____

Parent/Guardian #2 name and #: _____

ATTENTION DEFICIT/HYPERACTIVITY DISRODER	
Description: Implicated in learning disorders and one criteria is demonstrating several inattention, and/or hyperactivity/impulsivity symptoms.	
IF YOU SEE THIS:	**DO THIS:**
• Inattention: careless mistakes or poor attention to detail, poor organization, poor sustained attention, does not follow through or fails to finish tasks, does not seem to listen when spoken to, loses objects, easily distracted, forgetful in daily activities, avoids tasks requiring effort • Hyperactivity/impulsivity: fidgets, leaves seat, runs or climbs excessively, difficulty playing quietly, always "on the go," talks excessively, blurts out answers, can't wait turn, interrupts others.	1. reinforce any behavioral management goals 2. medication as ordered by the physician 3. observe for possible medication side effects: lack of appetite, nausea, stomachache, headache, insomnia, weight loss, may exacerbate tics or tourette's syndrome, increased anxiety/nervous habits, mood lability or irritability, apathy or the "zombie effect," increased heart rate, increased blood pressure.

TO BE REVIEWED AND SIGNED BY PARENT/GUARDIAN

I give permission to the school nurse/health clerk and other designated staff members of District 68 to perform and carry out the emergency care plan as outlined by this emergency health care plan. I also consent to the release of the information contained in this emergency health care plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

_____ _____
Parent Signature Date

TO BE COMPLETED BY PHYSICIAN OR LICENSED PRESCRIBER UPON REVIEW AND APPROVAL

Medications student takes at home: _____

Medication to be taken at school for this condition: _____

_____ _____
Physician signature Date

This form shall be effective for the current school year only, and must be renewed each subsequent school year.