Plan of Care for ADD/ADHD

Child's Name:_______________________________Date of Birth:__________Age:____
Program Site:__________________________________ School Year________________

Medications your child uses for ADD/ADHD:

Name	Dosage	Time of day given

Would any of the above medication(s) need to be given during program hours? ___Yes* ___No
If yes, a medication form must be filled out by the physician and returned **before your child can receive any medication.*

Control of the Program Environment:
During program time, a wide variety of activities are offered, in the school's cafeteria, gym, a classroom or on the playground. Often activities are stimulating for a child with ADD/ADHD. Please list any ideas or suggestions that would help the staff to care for and communicate with your child in this type of setting:

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Social/Family
All children have difficulty in peer interactions at times. Describe the types of difficulties your child experiences. Please offer ideas/suggestions on how the staff might help your child through these times:

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Is there any information regarding your family's situation, as it relates to your child's behavior, which would be helpful in the care of your child? (i.e. recent change in marital status, living situation, job change/loss, death of a loved one, etc.):

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Is your child receiving therapy i.e., psychological, behavior, social?

___Yes ___No If yes, how frequently? And what are the goals of the therapy?

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_____________________________ _____________________________

Parent/Guardian Signature & Date *Site Director Signature & Date*

Review of above information and signature for ____________school year in LEARN.

_____________________________ _____________________________

Parent/Guardian Signature & Date *Site Director Signature & Date*

Review of above information and signature for ____________school year in LEARN.

_____________________________ _____________________________

Parent/Guardian Signature & Date *Site Director Signature & Date*