

**Calallen ISD Health Services**  
**ADD/ADHD INDIVIDUAL HEALTH PLAN**

NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ School Year : \_\_\_\_\_

**PLAN/GOAL:** To help the student to achieve his/her highest learning potential

1. Provide classroom teacher with suggestions if/when requested by teacher.
2. Give medication as prescribed and monitor medication compliance and side effects.
3. Communicate with health care provider/MD and parents regarding concerns as appropriate.
4. Provide support and encouragement to the student as needed.
5. Obtain physician orders for medication when it is medically necessary to be administered in the school setting.

**The following to be completed by the health provider:**

Diagnosis \_\_\_\_\_

Medication (generic name if used) \_\_\_\_\_

Dosage amount: \_\_\_\_\_ Time to administered at school: \_\_\_\_\_

Allergies: \_\_\_\_\_ Possible Side Effects : \_\_\_\_\_

Physician Name (print) \_\_\_\_\_ Date of request \_\_\_\_\_

**Physician signature** \_\_\_\_\_ **Phone** \_\_\_\_\_

I understand that a person who is not medically licensed may administer the medication and/or treatment. I understand that: (1) that in accordance with Texas Education Code 21.905 medication is defined as: substances used to prevent, diagnose, cure, or relieve signs and symptoms of disease; (2) there is no liability on the part of Calallen I.S.D. or it's employees for administration of medicine requested by the parent/guardian and for adverse reactions or side effects to the medication; (3) I agree to be responsible for maintaining an adequate supply of medications at the school to meet the child's needs; (4) this medication will be brought to school only by a parent/guardian; (5) that my child will not be in possession of any medication at any time unless they have written permission from a physician stating they have a condition that requires immediate treatment; (6) this medication will be "properly labeled" as defined in the Calallen I.S.D. Nursing policy manual; (7) this medication will be destroyed if it is not picked up; (8) in accordance with the Nurse Practice Act, Texas Code, Section 217.11, The school nurse has the responsibility and authority to refuse to administer medications that in the nurse's judgment are not in the best interest of the student. I hereby authorize the exchange of medical information regarding my child's medication/treatment plan between the physician and Calallen I.S.D. Health Services Department.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

The attending physician must renew medication orders and this release signed by the parent/guardian annually. The most current physician's order and label on medication must have matching information. Consequently, if these do not match your child will **not** receive the medication at school.

**FOR OFFICE USE ONLY**  
**MEDICATION AMOUNT RECEIVED**

| Date | Count | Parent/Guardian Signature | Initials | Date | Count | Parent/Guardian Signature | Initials |
|------|-------|---------------------------|----------|------|-------|---------------------------|----------|
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|      |       |                           |          |      |       |                           |          |

IHP received and uploaded to student's health record: Date: \_\_\_\_\_ By: \_\_\_\_\_

**UNUSED MEDICATION PICKED UP BY:** PARENT/GUARDIAN \_\_\_\_\_ **DATE:** \_\_\_\_\_

Revised 9/2022