INFORMATION FOR THE STUDENT WITH ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD)

Student _____ Date of Birth _____

Parent's Name _____ Home Number _____

Work Number _____

_____ Home Number _____

Work Number _____

Address _____

Receiving Treatment Yes No

Taking Medication Yes No

Name _____ Dosage _____ Frequency _____

Possible Side Effects _____

Will this medication be administered at school? Yes No

Describe "typical" symptoms (triggers):

_____

_____

Treatment Protocol (to be completed by physician)

_____

_____

_____

_____ _____

Physician's Signature Date

_____ _____

Parent's Signature Date

Revised: 1/21/2020