School District of Iola-Scandinavia-Confidential

Health Services: ADD/ADHD

Students Name:	Date of Birth:
Grade:	School Year:
Bus student: (Circle one) YES NO	

1. Does your child take medication for ADD/ADHD? _____ Yes _____ No

   - If yes, name of medication(s) and dosage:

     _____

   - Times(s) of day medication(s) are taken:

     _____

   *If your child requires medication at school, you must have a REQUEST FOR GIVING MEDICATION FORM signed by the doctor and parent, on file for this year, BEFORE THE MEDICATION CAN BE GIVEN.

2. Does your child attend any other therapies such as counseling? □ Yes □ No

3. When was your child diagnosed with ADD/ADHD? _____

4. How often does your child see the doctor regarding ADD/ADHD:

_____

5. What is the date of your child's last evaluation? _____

6. Does the doctor require school evaluation? □ Yes □ No

7. Are classroom modifications needed? □ Yes □ No If yes, what has helped in the past? (Use other side if needed)

_____

_____

_____

_____

_____

Please fill out back of form…

8. What additional information will help school staff understand your child's ADD/ADHD?

-Attention Span/Concentration Concerns:

_____

_____

-Social/Skills/Self Esteem:

_____

_____

-Risk Taking/Coping Skills:

_____

_____

Doctor(s) Treating ADD/ADHD: _____ Phone: _____

Doctors Address: _____

Mother	Father	Other
Name:	Name:	Name:
Home Phone:	Home Phone:	Home Phone:
Cell Phone:	Cell Phone:	Cell Phone:
Work Phone:	Work Phone:	Work Phone:
E-mail Address:	E-mail Address:	E-mail Address:

Authorization is hereby granted to release this information to appropriate school personnel and classroom teacher to ensure safe management of your child's condition. If there are any questions or changes in this plan, please inform the School Nurse and/or office staff as soon as possible.

Parent/or legal guardian Signature: _____Date: _____

School Nurse Signature: _____Date: _____