INDIVIDUAL HEALTH PLAN – ADHD

Student Name _____Birthdate_____Grade/Teacher_____

School Name_____ School Year_____

Doctor Treating ADHD_____Phone#_____

1. Does your child take medication for ADHD: □ Yes □ No
   a. If yes, name of medication(s) and dose (s): _____
   b. Time(s) of day medication (s) are taken:_____

If your child requires medication at school, you must have a **Prescription Medication Permission Form** signed by doctor and parent on file **BEFORE** the medication can be given.

2. What other therapies or treatments, such as counseling are being used:_____
3. When was your child diagnosed with ADHD:_____
4. How often does your child see the doctor regarding ADHD:_____
5. What is the date of your child's last ADHD medical evaluation: _____
6. Does the doctor require school evaluation information: □ Yes □ No
7. Are classroom modifications needed: □ Yes □ No
   a. If yes, what has help in the past? (Use other side if needed):_____

   _____
8. What additional information will help school staff understand your child's ADHD:

   □ Attention Span/Concentration Concerns:_____

   _____

   □ Social Skills/Self Esteem:_____

   _____

   □ Risk Taking/Coping Skills: _____

   _____

   □ Other concerns:_____

   _____

School Nurse Signature: _____ Date Reviewed: _____