MT. PLEASANT CENTRAL SCHOOL DISTRICT

825 WESTLAKE DRIVE
THORNWOOD, NY 10594
FAX # 914-769-4608

COMMITTEE ON SPECIAL EDUCATION/SECTION 504

(TO BE COMPLETED BY THE PROFESSIONAL PROVIDING DIAGNOSIS)

Name of Student: _____

Physician's Name & Address: _____

_____

_____

_____ I can confirm that the criteria for ADD/ADHD have been met based upon DSM-V diagnostic symptoms:

DSM V Diagnosis: _____314.00 Predominantly Inattentive Type

_____314.01 Predominantly Hyperactive-Impulsive Type

_____314.01 Combined Type

Date of Diagnosis:_____

I have utilized the following diagnostic material(s):

_____Medical, developmental, behavioral, social/family history
_____School records and history
_____Parent Rating Scale
_____Teacher Rating Scale
_____Diagnostic testing (cognitive, neuropsychological)
_____Diagnostic interview
_____Physical examination
_____Continuous performance test
_____Informal interview data/observations
_____Behavioral observations

Other known/suspected associated problems:

_____Medical _____Psycho-social/environmental

_____Neuro-developmental _____Learning _____Behavioral/emotional

Physician's Name (PLEASE PRINT)_____

Physician's Signature_____Date_____