

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: _____