

**DISTRICT 4J SCHOOLS
HEALTH SERVICES**

Student Name _____ School _____

Date of Birth _____ Date _____ Grade _____

ADD - ADHD ASSESSMENT

You have checked on school records that this student has **Attention Deficit or Attention Deficit Hyperactivity**. Please complete this form & return it to your student's school so that appropriate information may be shared with school personnel. Your school nurse is available for consultation.

What year/grade was ADD or ADHD diagnosed? _____

ADD – ADHD is being treated by Dr. _____ Phone _____

IS MEDICATION NEEDED TO TREAT THE ADD – ADHD? Yes _____ No _____

MEDICATIONS

AMOUNT TAKEN

WHEN - TIME

1. _____

2. _____

(Circle number of any of these medications to be taken at school.)

Other treatment for the ADD or ADHD? _____

What are the most common strengths your student has at school? _____

What are the most common difficulties your student would have at school? _____

What can the school do that would be helpful? _____

Do you have concerns about learning difficulties? _____

Does your student have an active IEP or educational plan? _____

Student Name _____

Parent/Guardian Contact #1

Emergency Contact #2

Emergency Contact #3

Name _____ Name _____ Name _____

Relationship _____ Relationship _____ Relationship _____

Address _____ Address _____ Address _____

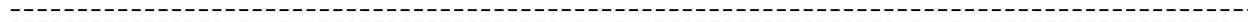
Phone: (H) _____ (W) _____ Phone: (H) _____ (W) _____ Phone: (H) _____ (W) _____

Cell _____ Cell _____ Cell _____

To provide for your child's educational experience the above information will be shared with school staff, included in your child's school health record and may be shared electronically.

Signature of Parent/Guardian Date

RETURN THIS FORM TO THE SCHOOL



DATE

SIGN / INITIAL

STUDENT COMPUTER SYSTEM ENTRY _____

INFORMATION SHARED WITH STAFF _____

Additional notes: _____
