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?_____

HS:ADD-ADHD rev 11-13

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:_____

_____

_____

_____

_____

_____