MEDICAL INFORMATION / ADHD

TO BE COMPLETED BY THE PARENT

Patient's Name: _____ **DOB:** _____

Address: _____ **Phone:** _____

Physician's Name: _____ **Date of Exam:** _____

Parent Signature: _____ **Date:** _____

The following information may not be released unless a parent has signed this form or a **"Release of Information"** is attached.

TO BE COMPLETED BY THE PHYSICIAN

I met with _____ **on the following date(s)** _____ **for a period of** _____ **hrs.**

PART I **Presenting Complaints: (Check)**

	School	*Home*		*School*	*Home*
Inattention	❑	❑	*Social problems*	❑	❑
Hyperactivity	❑	❑	*Difficulty delaying gratification*	❑	❑
Impulsive	❑	❑	*Non-compliance*	❑	❑
Disorganization	❑	❑	*Anxiety/Over-aroused*	❑	❑
Restlessness	❑	❑	*Other (explain below)*	❑	❑

Comments/pertinent information:

_____

_____

PART II **Attention Deficit Hyperactivity Disorder Diagnosis**

❑ **I cannot confirm a diagnosis due to the following reason:**
- ❑ *Does not meet diagnostic criteria*
- ❑ *Additional information is required*
- ❑ *Specific information requested from school*
- ❑ *Other referrals/treatments planned*

❑ **I can confirm a diagnosis:** *(Please complete sections III, IV, and V and sign on page 2)*

Physician's Signature: _____ **Date:** _____

RETURN THIS FORM TO: **Name:** _____ **School:** _____

Address: _____

(over)

WAKE COUNTY PUBLIC SCHOOL SYSTEM

PART III

❑ **I can confirm that criteria for Attention Deficit Hyperactivity Disorder have been met based on the DSM-IV (Diagnostic and Statistical Manual of the American Psychiatric Association) and after a review of the following material:**

❑ *Medical, developmental, behavioral, social and family history.* ❑ *Physical examinations*

❑ *School History* ❑ *Parent and teacher behavior rating scales.* ❑ *Assessment(s) by other consultants/specialists. Please specify:* _____.

_____

Other known/suspected associated/concurrent problems which may impact school performance.

Please explain

❑ Medical _____

❑ Neuro developmental _____

❑ Behavioral/emotional _____

❑ Psychosocial/environmental _____

PART IV

Is the child presently on any medication? ❑ No ❑ Yes If yes, please specify: _____

Type: _____ Dosage: _____ Frequency: _____

* Time of doses to be given at school _____

Anticipated side effects: _____

Do you plan a medication trial? ❑ No ❑ Yes If so, when would you like baseline and follow-up rating scales? Baseline Date: _____ Follow-up Date: _____

*Please write separate prescription for medication to be administered at school assuring labeled original container.

PART V

Does the child's condition result in limited strength, alertness, vitality or other difficulties to the extent that it may impact school performance? ❑ No ❑ Yes Explain: _____

_____

Physician's signature _____ **Date:** _____