GRAVES COUNTY SCHOOLS
MEDICAL FORM FOR ADD/ADHD
STUDENT'S NAME_____
DATE_____ **SCHOOL**_____

1. This student was first diagnosed with ADD/ADHD on _____

2. My diagnosis is:
□□DSM IV 314.00 – ADD □□DSM IV 314.01 – Combined Type (ADD/ADHD)
□□DSM IV 314.01 – ADHD □□□This child does not meet the criteria for ADD/ADHD

3. Other significant co-morbid problems present ____ NO ____YES
   1._____
   2._____

4. Current medications for this student

NAME OF MEDICATION(S)	DOSE	TIMES PER DAY
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. FUNCTIONING AT THIS TIME
   Extreme/Significant Problems Substantial Problems Moderate Problems
   Mild Problems Negligible/No Problems

6. <u>Possible Problems</u> in the school/classroom setting in regards to (*Please be specific*)
   1. Strength_____
   2. Alertness_____
   3. Vitality_____
   4. Other_____

PHYSICIAN SIGNATURE_____

PHYSICIAN SIGNATURE (PRINTED)_____

PARENT SIGNATURE_____DATE_____