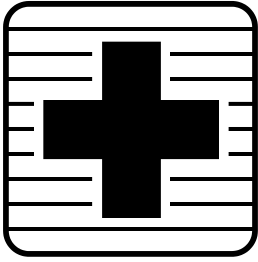

School District of Tomorrow River

HEALTH SERVICES

Heather Schultz, School Nurse

357 N. Main Street, Amherst, WI 54406 Phone (715)824-5523 ext. 425 Fax (715)824-5474

Student's Name:	**DOB:**
School Attending:	**Grade:**
Date:	**Bus Student:** Yes No
Health Condition: ADD/ADHD	

1. **Does your child take medication for ADD/ADHD? ___ Yes ___ No**
   - **If yes, name of medication(s) and dosage: ____________________**
   - **Times(s) of day medication(s) are taken: ____________________**

***If your child requires medication at school, you must have a REQUEST FOR GIVING MEDICATION FORM signed by the doctor and parent, on file for this year, BEFORE THE MEDICATION CAN BE GIVEN.**

2. **Does your child attend any other therapies such as counseling?**
   - ☐ **Yes**
   - ☐ **No**

3. **When was your child diagnosed with ADD/ADHD? ____________________**

4. **How often does your child see the doctor regarding ADD/ADHD: ____________________**

5. **What is the date of your child's last evaluation? ____________________**

6. **Does the doctor require school evaluation?**
   - ☐ **Yes**
   - ☐ **No**

7. **Are classroom modifications needed?**
   - ☐ **Yes**
   - ☐ **No**

   If yes, what has helped in the past? (Use other side if needed)____________________
   ____

8. **What additional information will help school staff understand your child's ADD/ADHD?**
   - ☐ **Attention Span/Concentration Concerns ____________________**
   ____
   - ☐ **Social/Skills/Self Esteem ____________________**
   ____
   - ☐ **Risk Taking/Coping Skills ____________________**
   ____

Contacts

Mother	**Father**	**Other**
Name: ________	**Name:**________	**Name:** ________
Home #: ________	**Home #:** ________	**Home #:** ________
Work #: ________	**Work #:** ________	**Work #:** ________
Cell #: ________	**Cell #:** ________	**Cell #:** ________

Doctor(s) Treating ADD/ADHD: ____________________ Phone: ____________________ Fax: ________

Doctors Address: ____________________

Authorization is hereby granted to release this information to appropriate school personnel and classroom teacher.

Parent Signature: ____________________ Date: ____________________

School Nurse Signature: ____________________ Date: ____________________

Rev.8/12