

Medical Form
Attention Deficit Hyperactivity Disorder
Sevier County Schools/Department of Special Education

Student _____ School _____

Date of Birth ___/___/___ Parents _____

Address _____ Phone _____

This student has been referred for special education services. Please refer to school data. Medical information is needed to assist in determining the need for special education for this student. The information will be confidential and used only by persons directly involved with the student.

(Please respond to each item.)

Diagnosis/Etiology: ADHD: (Indicate Type) Inattentive Hyperactive Combined
 Does not meet criteria for ADHD
 Other _____

Prognosis _____

Is a psychological evaluation available supporting the attention deficit diagnosis? Yes No

Impact of diagnosis on educational performance: _____

Treatment: _____

Medication: (+Dosage) _____

Type: _____

Please make the most appropriate recommendation as to how this student can best function in an educational environment:

PLEASE COMPLETE CHECKLIST ON SECOND SHEET