

Office of the School Nurse

Dear Physician,

_____ was seen in your office. In an effort for all communication between the parents, the school and yourself, to be accurate, please complete this form. I appreciate the time invested in this assessment. Type name, title and phone number.

_____ An initial diagnosis of Attention Deficit or Attention Deficit Hyperactivity Disorder was made.

The decision was made to place the child on a trial regime of:

_____ to be given at home only.

_____ to be given at home and at school.

_____ A diagnosis was not made at this time. The child/family was referred for further assessment by: _____.

Additional documentation is needed.

Parents would like more time to consider the diagnosis.

This is a follow-up visit and the established regime will continue.

There will be a change in the medication regime:

The at-home medication/dosage will be _____

The school medication/dosage will be _____

_____ has been discontinued.

PARENTS, PLEASE RETURN THIS FORM TO THE SCHOOL NURSE.