Ira Independent School District

ADD/ADHD Action Plan

Student Name: _____ DOB: ___/___/___

Parents/Guardians caring for child:_____

Home phone:_____

PRIMARY CONDITION

Diagnosis:		Date of diagnosis:		
Symptoms/basis of diagnosis:				
Does student take medication at home?				
Will student need medication while at school?				
MEDICATION				
Medication at home:				
Name of medication	Dose	Frequency	Time of day	Special instructions
Medication at school:				
Name of medication	Dose	Frequency	Time of day	Special instructions

COMORMID/OTHER CONDITIONS

Diagnosis:	Date of diagnosis:

_____ _____

Physician signature Date