School District
Medication Effects at School Review

Student's Name _____ Date of Birth_____ School_____

Medication:_____Dosage Schedule_____Taken __at home __at school

Reviewer's Name(s)_____Position(s)_____Date of Review_____

Check the area(s) that apply to this review:

___Baseline report (student receives no medication) ___After [_____] week(s) of medication

___Change in medication dose or administration schedule [from _____ to _____]

Parent/Guardian authorization for two-way release of information

I hereby authorize two-way communication between the _____School District and the person(s) listed below:

Name(s)_____

Parent/Guardian Signature_____ Date_____

Please check behaviors observed consistently or mentioned by the student frequently.

Classroom Behaviors	Improved	Same	Worse	Comments
Attention to tasks				
Listening to lessons				
Finishing assignments				
Keeping up with possessions				
Neatness of written work				
Following directions				
Time management				
Interaction Behaviors	**Improved**	**Same**	**Worse**	**Comments**
Following rules				
Remaining seated when appropriate				
Turn-taking/sharing				
Thinking before speaking/acting				
Self-control of disruptive behaviors				
Physical control of fidgeting/ restlessness				
Remorseful over misbehavior				
Side Effect Behaviors	**Improved**	**Same**	**Worse**	**Comments**
Loss of appetite				
Headaches				
Stomachaches				
Tiredness, sleeping in class				
Irritability				
Staring or "spacing out"				
Crying, sadness				
Vocal or motor tics				
Nervousness, nail-biting, chewing things				
Aggressiveness toward others				
Temper tantrums				
Withdrawal				

Faxed or mailed on_____