ADHD Management Plan—Sample 2

Patient ________________'s doctor is ________________ Pager # ________

Parent/Guardian ________________ Relationship ________________

Contact Number(s) ________________

School Name ________________ School Phone No. ________________

Key Teacher Contact Name ________________ Grade Level ________

Teacher's E-mail Address ________________ Fax No. ________

Goals What improvements would you most like to see?

____

____

____

Plans to reach these goals:

1. ________________
2. ________________
3. ________________

Medication

1. ________________	Time ______ am/pm	Time ______ am/pm	Time ______ am/pm
	Dose 1 ______ mg	Dose 2 ______ mg	Dose 3 ______ mg
2. ________________	Time ______ am/pm	Time ______ am/pm	Time ______ am/pm
	Dose 1 ______ mg	Dose 2 ______ mg	Dose 3 ______ mg

Further Evaluation

☐ Parent Assessment received and follow-up appointment scheduled for ____/____/____

☐ Teacher Assessment will be done by Ms/Mr ________________

☐ School testing scheduled on this date ____/____/____

Additional Resources and Treatment Strategies

☐ Behavioral Modification Counseling Referral to ________________

☐ Parenting Tips Sheet given

☐ Parent Follow-up form completed ____/____/____

☐ Teacher Follow-up form completed ____/____/____

☐ CHADD phone number given: 800/233-4050

Common Side Effects

Decreased appetite
Sleep problems
Transient headache
Transient stomachache
Behavioral rebound

If Any Infrequent Side Effects Occur, Call Your Doctor Immediately!

Weight loss
Increased heart rate and/or blood pressure
Dizziness
Growth suppression
Hallucinations/mania
Exacerbation of tics and Tourette syndrome (rare)

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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