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	If Any Infrequent Side Effects Occur, Call Your Doctor Immediately!
Decreased appetite	Weight loss
Sleep problems	Increased heart rate and/or blood pressure
Transient headache	Dizziness
Transient stomachache	Growth suppression
Behavioral rebound	Hallucinations/mania
	Exacerbation of tics and Tourette syndrome (rare)

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals