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)

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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