

OBSERVATIONS OF EFFECT OF MEDICATION

Student's Name: _____ Grade _____ DOB _____

Date: _____ Form Completed by (name): _____

School _____ Medication(s) at school _____

Dosage _____ Frequency _____

Other Medications taken? Yes _____ No _____ Name _____ Dosage _____

Frequency _____ Is medication taken regularly? Yes _____ No _____

<u>Observation</u>	Marked Improvement	Minimal or Questionable	No Improvement	Worse
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1. Restlessness that includes hands or feet, squirming in his/her seat	_____	_____	_____	_____
2. Easily distracted by extraneous stimuli	_____	_____	_____	_____
3. Difficulty in following through on instructions due to oppositional behavior or failure to comprehend	_____	_____	_____	_____
4. Difficulty in waiting turn in games or groups	_____	_____	_____	_____
5. Difficulty in sustaining attention in tasks or at play	_____	_____	_____	_____
6. Often shifting from one incomplete task to another	_____	_____	_____	_____
7. Often engaging in physically dangerous activities without considering possible consequences	_____	_____	_____	_____
8. Often irritable with occasional outbursts	_____	_____	_____	_____
9. Sleeps or appears tired during class time	_____	_____	_____	_____
10. Gets along with peers and teachers	_____	_____	_____	_____

Side effects noted/comments: _____
