SUMTER COUNTY SCHOOLS
SCHOOL HEALTH SERVICES

ATTENTION DEFICIT HYPERACTIVITY DISORDER
PARENT INTERVIEW GUIDE

Student's Name: _____ Date of Birth: _____

Student's Address: _____

Age: _____ Grade: _____ Teacher: _____ School: _____

Parent/Guardian: _____ Phone: _____
Cell Ph: _____

Physician Name: _____ Phone: _____

1. What is/are your child's diagnosis? _____

2. How long has your child had symptoms of the diagnosis? _____

Severity: (Please circle one) MILD MODERATE SEVERE

3. What are his/her usual signs and symptoms? _____

_____

4. Are there any specific events or activities that seem to worsen symptoms? _____

_____

5. What type of medication does your child take and when? _____

_____

6. What physical, emotional, mental, behavioral, or social problems does your child have, if any? _____

_____

_____

7. Any special instructions including needs for special health requirements in the classroom or at school?

_____

_____

Please make sure that we have your correct phone number, where you can be reached at all times.

As parent/guardian by signing this form, I give permission for Sumter County Schools to share this information with the faculty and staff who are directly involved in my child's education and/or school health services.

_____ _____ _____

Parent signature Please Print name Date