



Health Services

Behavior Evaluation (Confidential)*

Name: _____

Date: _____

Campus: _____

DOB: _____ ID#: _____

Grade: _____ Homeroom: _____

Please check the appropriate spaces below. This will help the doctor to understand the situation and to adjust his/her medication.

Medication: Yes Name of Medication _____ Dosage _____

	A LITTLE	QUITE A BIT	EXCESSIVE	BETTER	SAME	WORSE
Rowdiness						
Wigginess						
Out of Seat						
Not Attentive:						
To Teacher						
To Own Desk Work						
Talks to Self						
Talks Out of Turn						
Irritable						
Crying						
Quiet & Withdrawn						
Stubborn						
Belligerent						

	GOOD	FAIR	POOR	BETTER	SAME	WORSE
Interest in Work						
Follows Directions						
Seems Content						
Gets Along With Others						
Reading/Spelling						
Writing						
Arithmetic						
Other Comments (See below)						

Time of day in this class _____

Comments _____

*For use with students having been on the same dosage of behavior altering medication for 2 weeks or longer

Please return to school nurse.