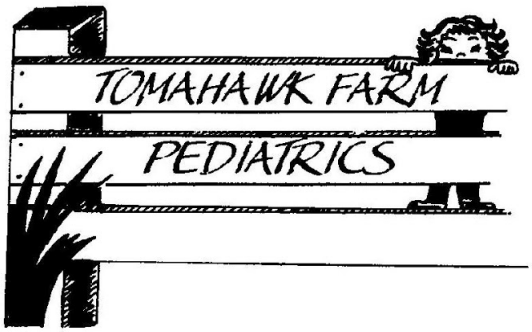

Medication Name & Dose: _____

Pharmacy (REQUIRED): _____

Patient Name: _____ **DOB:** _____

Prescription Pick-up Date: _____

How has your child been doing in school this month?

_____ Poor _____ Fair _____ Good _____ Excellent

Has there been any feedback from school this month?

_____ Yes _____ No

Has there been any significant change in behavior?

_____ Yes _____ No

Have there been any new medications prescribed to your child this month by another physician?

_____ Yes _____ No If yes, please specify _____

Have you noticed any adverse reaction to the medication?

_____ Headache _____ Nausea _____ Weight Loss _____ Weight Gain

_____ Loss of Appetite _____ Increase or Decrease in Mood Swings

Have there been any disruptions or problems with your child's sleep this month?

_____ Yes _____ No

Please sign below that the information above is correct and that you have communicated any concerns with the physician.

_____ _____

Parents or Guardian Signature Date

Gregory Odell, MD • Jamie Odell, MD •

(914) 248-0500 • Fax:(914) 248-5478

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