HEALTHY CPS
— OFFICE OF STUDENT HEALTH & WELLNESS —

## Report on a Student with a Neurodivergent Condition

(STUDENT LAST NAME) (FIRST) (MIDDLE) (DOB) (ID #)

(HOME ADDRESS) (ZIP CODE) (TELEPHONE)

(PARENT'S/ GUARDIAN'S NAME) ( SCHOOL)

Please check Neurodivergent Condition(s):

Autism Spectrum Disorder: Level 1____ Level 2_____ Level 3____
Attention Deficit Hyperactivity Disorder ____ Bipolar____ Down Syndrome____
Dyslexia____
Dyscalculia___ Irlen Syndrome___ Obsessive-Compulsive Disorder___ Tourette Syndrome___
Sensory Processing Disorder___ Other (please state condition(s)) _____

**Treatment**
Therapy:_____ Frequency:_____
Medication: _____Dosage:_____Time:_____
Medication: _____Dosage:_____Time:_____
Medication: _____Dosage:_____Time:_____

Special Care
Instructions:_____
_____
How often should this student have a medical check-up? _____
Next scheduled appointment_____

Provider's Name **(PRINT)**_____
Hospital Affiliation _____
Address _____Telephone #_____
Fax #_____
**Provider's Signature** _____ **Date** _____