Elementary School

Medication Effects Checklist

Date: **Rater:**

Student Name: **ID#:** **Gr:** **D.O.B.:**

Behaviors Attention to task	Morning	Mid-Morning	Lunch/Recess	Lunch/Recess
Listening to lessons				
Following directions				
Finishing work				
Repetitiveness				
Talking out of class				
Organization				
Verbal activity				
Restlessness/ Fidgety				
Withdrawn				
Aggressiveness				
Irritable/ Argumentative				
Reacting/ cries easily				
Sensitive/ friends avoid				
Plays a lot/ disengages				
Sadness/ giving				
Nervous				

Rating time period:_____to:_____

School Behavior Problems:

Briefly state any positive comments or concerns:

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