Medication Effects Rating Scale

Name:	Date:
D.O.B.:	Completed by:
Grade:	School:

List name(s) of medication student is taking:

MEDICATION(S)	DOSAGE(S)	TIME(S) OF DAY TAKEN	DISPENSED BY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Mark any changes noticed in the following behaviours:

Behavior	**1 Not Yet Meeting Expectations** (worse)	**2 Minimally Meeting Expectations** (no change)	**3 Fully Meeting Expectations** (improved a little)	**4 Exceeding Expectations** (improved a lot)
attention to task	_____	_____	_____	_____
listening to lessons	_____	_____	_____	_____
finishing work	_____	_____	_____	_____
impulsiveness	_____	_____	_____	_____
calling out in class	_____	_____	_____	_____
organization, fine motor	_____	_____	_____	_____
overactivity	_____	_____	_____	_____
restlessness, fidgety	_____	_____	_____	_____
talkativeness	_____	_____	_____	_____
aggressiveness (swearing, threats, destroys property)	_____	_____	_____	_____

Mark any side effects noticed by you or mentioned by student:

Side Effects	**Comments**
appetite loss	_____
insomnia (as reported by home)	_____
headaches	_____
stomach aches	_____
seems tired	_____
stares a lot	_____
irritable	_____
vocal or motor tic	_____
sadness	_____
nervousness	_____

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