Rev. 8/2013

CUMBERLAND COUNTY SCHOOLS
Students Diagnosed with Emotional Disturbance

Student Name:		DOB:	Age:
Address:	City:	NC	Zip:
Parent/Guardian Name:			
Home Phone:	Work Phone:		

The following section is to be completed by a licensed psychiatrist.

	Diagnosis in infancy, childhood or adolescence Please indicate all that apply	Type	Pattern or History of Behavior
	Autistic Disorder		
	Asperger's Disorder		
	Attention Deficit/Hyperactivity		
	Conduct Disorder		
	Other		
	Anxiety Disorder		
	Panic Attack		
	Social Phobia		
	Obsessive Compulsive Disorder		
	Post-Traumatic Stress Disorder		
	Schizophrenia/other Psychotic Disorders		
	Other		
	Substance Related Disorders		
	Mood Disorders		
	Major Depression Episode		
	Depressive Disorder		
	Bipolar Disorder		
	Other		
	Eating Disorders		
	Anorexia Nervosa		
	Bulimia Nervosa		
	Factitious Disorder		
	Other		
	Personality Disorder		
	Paranoid		
	Schizoid		
	Antisocial		
	Obsessive Compulsive		
	Other		
	Psychiatrist additional comments:		

Physician's Signature:_____ Date:_____

Physician's Name (printed): _____ Phone Number:_____

Medical Specialty:_____ Physician ID Number:_____

Address:_____ City:_____ Zip:_____