Physical and Medical Disability Form

In order for us to provide disability-related services, we need to establish that this individual has a physical or mental impairment that limits one or more of the major life activities. This form is designed to help us make that determination.

Today’s Date: _________________________

Student’s Name:______________________________________ Student’s ID: _________________

**To Be Completed by the Student’s Physician**

1) Please state the complete diagnosis (inc. DSM):

_________________________________________________________________________________
_________________________________________________________________________________

2) How did you arrive at your diagnosis? Please check all relevant items below; adding brief notes that you think might be helpful to us as we determine which accommodations and services are appropriate for the student:

- Structured or Unstructured interviews  □  Medical tests  □
- Interviews with other persons  □  Medical History  □
- Behavioral Observations  □  Developmental History  □

3) Date of Diagnosis: ______________________________

4) This student has been under a physician’s care for this issue since: _________________________

5) Date student was last seen: ______________________________

6) How long is this condition likely to persist:  Permanent  Temporary:  Date:  _____________

7) How often is the student required to check-in with a physician?

- Once a week     - Once a month     - Every three-four months     - Every six months
- Once a year     - As needed     - Other:______________________

8) Is the student currently taking medication(s) for this issue?  YES  NO (see #9)

If yes, what medications is the student currently taking? For each medication, describe the side effects and any impact on academic performance. Do limitations/symptoms persist even with medications?

<table>
<thead>
<tr>
<th>Medication and Dosage</th>
<th>Side Effects</th>
<th>Academic Impact</th>
<th>Persistence of Symptoms</th>
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</table>
9) Please explain why the student is not taking any medication.

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

10) Please check which areas listed below the student is functionally limited in because of the medical diagnosis and/or the medication. Please indicate the level of limitation.

1= Unable to Determine  2= No Impact  3= Mild Impact  4= Moderate Impact  5= Substantial Impact

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Major Life Activities</th>
<th>Learning / Time Management</th>
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<td></td>
<td>Caring for Oneself</td>
<td>Memory</td>
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<td>Talking</td>
<td>Concentrating</td>
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<td>Hearing</td>
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<td>Breathing</td>
<td>Organization</td>
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<td>Seeing</td>
<td>Managing distractions</td>
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<td>Walking</td>
<td>Timely submission of</td>
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<td>Standing</td>
<td>assignments</td>
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<td>Lifting/Carrying</td>
<td>Attending class regularly</td>
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<td>Sitting</td>
<td>Making and keeping</td>
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<td>Performing Manual</td>
<td>appointments</td>
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<td>Eating</td>
<td>Managing stress</td>
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<td>Writing</td>
<td>Reading</td>
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<td>Working</td>
<td>Spelling</td>
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<td>Interacting with others</td>
<td>Quantitative reasoning (math)</td>
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<td>Sleeping</td>
<td>Processing Speed</td>
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</table>

11) What other specific symptoms manifesting themselves at this time might affect the student’s academic performance?

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

12) What is the student’s prognosis? How long do you anticipate that the student’s academic achievement will be impacted by his/her disability?

Circle one: 6 months  1 year  1-2 years  on-going  permanently  unknown

13) Have there been any changes in the student’s condition in the past 12 months? NO YES

Please explain.

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

14) Do you anticipate any changes in the student’s condition/medication in the next 12 months? NO YES

Please explain.

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
15) Is there anything else you think we should know about the student’s medical condition?

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Note: Qualified diagnosing professionals are licensed physicians and surgeons, and in some instances, chiropractors. The diagnosing professional must have expertise in the differential diagnosis of the documented disorder or condition, follow established best-practices in the field, and not be related to the patient.

PLEASE TYPE OR PRINT CLEARLY

Name/Title __________________________________________

Signature__________________________________________ Date: _________________

License/Certification #________________ State __________________________

Address __________________________________________

City, State, Zip Code________________________________

Phone ______________________ Fax ______________________

1/05/12