ST. EDWARD'S UNIVERSITY
Student Disability Services

Disability Verification for Students with Medical Disabilities for Academic Accommodation

The student listed below is seeking academic accommodations at St. Edward's University based on a disability. In order to establish eligibility, the student must provide current, comprehensive documentation that establishes the diagnosis/es and describes the impact on major life activities.
This form should be completed as thoroughly as possible, by an appropriate licensed professional that has conducted the assessment, made the diagnosis, or is currently treating the student. These persons are generally psychologists, psychiatrists, licensed counselors or medical doctors. SDS may reach out directly to providers for further clarification or additional information as needed.

Name:_____ SEU ID: _____

Date: _____ Phone: _____ SEU email: _____

For more information about our Documentation Guidelines and before completing this form, please visit: www.stedwards.edu/student-disability-services/documentation-and-forms

By completing this form, you are certifying that in your professional opinion, this student qualifies as a person with a disability under the Americans with Disabilities Act. For more information regarding the ADA, see: www.ada.gov

1. Diagnosis

Please list all relevant diagnoses: _____

_____

_____

_____

Date diagnosed: _____

Date of first contact: _____

Date of your last clinical contact with student: _____

2. Evaluation

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 eligibility

- ☐ Medical evaluation (x-ray, lab work, EKG, etc.)
- ☐ Structured or unstructured interviews with student.
- ☐ Interviews with other persons (i.e. parent, teacher, therapist).
- ☐ Behavioral observations.
- ☐ Neuropsychological testing. Attach documentation.
- ☐ Developmental history (if applicable please describe)

  _____

  _____

  Other (Please specify). _____

Approximate onset of diagnosis:

- ☐ Child-- approximate age:_____
- ☐ Adolescent-- approximate age: _____
- ☐ Adult-- approximate age:_____
- ☐ Unknown

Prognosis of disorder:

- ☐ Active
- ☐ Progressing
- ☐ Controlled
- ☐ In Remission
- ☐ Other: _____

Severity of symptoms

- ☐ Mild
- ☐ Moderate
- ☐ Severe

What is the expected duration of this disability?

_____

Present symptoms that meet criteria for diagnosis noted.

_____

_____

_____

3. Current treatment being received by student:

- ☐ Medication management

  Current medications: _____

  Medication side effects: _____
- ☐ Physical / Occupational therapy

  Frequency: _____
- ☐ Other (please describe): _____

Will student require local treatment/follow-up? If yes, please describe arrangements made.

☐ Yes _____

☐ No

Has the student been hospitalized for this condition? If so, list approximate dates and length of stay: _____

_____

4. Major Life Activities Assessment: Please check which of the following major life activities listed below are affected because of the student's impairment. Indicate the severity of the limitations.

Life Activity	Negligible	Moderate	Substantial	Don't Know
Communicating				
Concentrating				
Memory				
Managing external distractions				
Managing internal distractions				
Organization				
Writing				
Reading				
Hearing				
Seeing				
Eating				
Sleeping				
Self-Care				
Meeting Deadlines				
Attending class				
Stress Management				
Social Interactions				
Mobility, please explain:				
Other:				

What specific symptoms/functional limitations based on the diagnosis does the student have that might affect him/her in the academic setting?

_____

_____

_____

Are there any situations or environmental conditions that might lead to an exacerbation of the condition?

_____

_____

State specific recommendations regarding academic accommodations for this student, and a rationale as to why these accommodations/services are warranted based on the student's functional limitations.

_____

_____

Please provide any additional information you feel will be useful in determining appropriate accommodations and interventions:

_____

_____

_____

Provider Information

I certify, by my signature below, that I conducted or formally supervised and co--signed the diagnostic assessment of the student named above.

Signature: _____Date: _____

Print Name and Title: _____

State of License: License Number: _____

Address: _____

Street or P.O. Box City State Zip

Phone:_____ Fax:_____

In an effort to be green, we would prefer this form be returned to SDS via email:

St. Edward's University
Student Disability Services
3001 S. Congress Ave Austin, TX 78704
Moody Hall 155
Email: sds@stedwards.edu
Fax: 512-464-8830

Adapted from: The University of Vermont ACCESS/Academic Support Programs, The University of Texas at Austin Services for Students with Disabilities, The Ohio State University Office for Disability Services