

Mobility Accommodation Support Form

NOTE: *Please type or print your answers on this form.*

Student Information

Student Name: _____
Student ID Number: _____
Campus Address: _____
Local Phone Number: _____
Date of Birth: _____
Date of Evaluation: _____

Diagnosis

Please list this individual's diagnosis(es) and give a brief explanation of each. _____

Symptoms and Severity

Please list this individual's current symptoms and indicate their severity (mild, moderate, severe). _____

Age of Onset

Age of onset _____ Date of onset _____

Prognosis

Please describe the prognosis. _____

Prescribed Treatment (if any)

Please list prescribed treatments, care, assistive devices, etc. and list any activities that would be contraindicated by this individual's condition. _____

Impact of Mobility Impairment on Daily Living and Classroom Activities

Please describe current impact of the impairment on activities of daily living and classroom activities. _____

Current Impact of Condition or Medication on Cognitive Functioning

Please describe the effects, if any, of the condition or prescribed medications on cognitive functioning. _____

Recommendations for Accommodations/Referrals

- | | |
|---|---|
| <input type="checkbox"/> Audio format of written course materials | <input type="checkbox"/> Lab assistant |
| <input type="checkbox"/> Extended time for exams (time and a half) | <input type="checkbox"/> Note taking assistance |
| <input type="checkbox"/> Extended time for exams (double time) | <input type="checkbox"/> Service animal |
| <input type="checkbox"/> Scribe for scantron exam forms | <input type="checkbox"/> Reader for exams |
| <input type="checkbox"/> Computer to type answers to exam questions | <input type="checkbox"/> Scribe for essay exams |

Allowance to take breaks, as needed, during class. Please give reason. _____

Accessible classroom furniture, such as adjustable tables or special seating. Please describe. _____

Absence leniency during periods of exacerbation, due to a compromised immune system, or for medical treatments. If recommending this accommodation, please specify the reason for absences and estimate the frequency of absences given the student's current condition. _____

Housing accommodations. Please list and give specific measurements, as needed. _____

Referral for further assessment. Please indicate all that apply

Alcohol and drug

Depression

Anxiety

AD/HD

Learning Disability

Other accommodations or referrals. Please list. _____

Evaluator Information

Evaluator Name: _____

Evaluator Title: _____

Evaluator Signature: _____

Address: _____

Phone Number: _____

Fax Number: _____

Email Address: _____