

Chronic Health Conditions: 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

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

Impact on Cognitive Functioning

Please describe current impact of the condition or medication on cognitive functioning. _____

If any objective tests of cognitive functioning have been administered, please attach those test results, including standard scores and percentile ranks, as well as any interpretive summary.

Current Impact of Condition or Medication on Academic Functioning

Please describe the effects of the condition or prescribed medications on academic 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 |
| <input type="checkbox"/> 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: _____