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

- ☐ Audio format of written course materials
- ☐ Extended time for exams (time and a half)
- ☐ Extended time for exams (double time)
- ☐ Scribe for scantron exam forms
- ☐ Computer to type answers to exam questions
- ☐ Lab assistant
- ☐ Note taking assistance
- ☐ Service animal
- ☐ Reader for exams
- ☐ 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: