Disability Verification for Academic Accommodations

The student listed below is seeking academic accommodations at Trinity 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 a diagnosis, or is currently treating the student. These persons are generally psychologist, psychiatrists, licensed counselors or medical doctors. SAS may reach out directly to providers for further clarification or additional information as needed.

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 (required) using the DSM-V:
   
   **For Individuals with ADHD:**
   
   Diagnosis (required) please check below:
   
   - [ ] 314.01 Combined presentation
   - [ ] 314.00 Predominantly inattentive presentation
   - [ ] 314.01 Predominantly hyperactive/impulsive presentation

   Date Diagnosed: ____________________________________________
   
   Date of first contact: _______________________________________
   
   Date of your last clinical contact with student:__________________

   Name: ___________________________  TU ID: _____________________
   
   ___________________________ Date: _______  Phone: ________________
   
   ___________________________ TU email: ______________________
2. Evaluation
In addition to DSM criteria, 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 for accommodations.

- Medical Evaluation (x-ray, laboratory tests, EKG, etc.)
- Structured or unstructured interviews with student
- Interviews with other persons, please list: ___________________________
- Behavioral observations
- Developmental history (if applicable please describe) ___________________________
- Educational History (if applicable please describe) ___________________________
- Neuro-psychological testing. Date(s) of testing? ________________ Please attach.
- Standardized or non-standardized rating scales
- Other. (Please specify) ___________________________

Appropriate onset of diagnosis:
- Child—appropriate age: ______
- Adolescent – appropriate age: ______
- Adult—appropriate age: ______
- Unknown

<table>
<thead>
<tr>
<th>Severity of symptoms</th>
<th>Prognosis of disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Active</td>
</tr>
<tr>
<td>Moderate</td>
<td>Progressing</td>
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<tr>
<td>Severe</td>
<td>Controlled</td>
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<td></td>
<td>In Remission</td>
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<td></td>
<td>Other: __________</td>
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</table>

Expected duration of disability: __________________________________________

Present Symptoms: _______________________________________________________

Hospitalizations related to disability: _____________________________________

Dates and Duration: ______________________________________________________

3. Current treatment being received by student:
- Medication management
  - Current medications:
    - Medication side effects ________________ _______________________________
  - Other: ___________________________
- Outpatient therapy
  - Frequency: ___________________________
- Group therapy
  - Frequency: ___________________________
4. Major Life Activities Assessment: Please check which of the following major life activities listed below are affected by the student’s diagnosis. Indicate the severity of the limitations.

<table>
<thead>
<tr>
<th>Life Activity</th>
<th>Negligible</th>
<th>Moderate</th>
<th>Substantial</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concentrating</td>
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<tr>
<td>Memory</td>
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<tr>
<td>Organization</td>
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<tr>
<td>Managing external distractions</td>
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<td>Managing internal distractions</td>
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<tr>
<td>Reading</td>
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<td>Writing</td>
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<tr>
<td>Sleeping</td>
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<td>Communicating</td>
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<tr>
<td>Mobility</td>
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<tr>
<td>Eating</td>
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<tr>
<td>Self-Care</td>
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<tr>
<td>Social Interactions</td>
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<tr>
<td>Attending Class</td>
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<tr>
<td>Other:</td>
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</tbody>
</table>

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

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

What environmental conditions might lead to exacerbation of symptoms?

__________________________________________________________________________
__________________________________________________________________________

Please provide any additional information you feel will be used in determining appropriate
In an effort to be green, we would prefer this form be returned to SAS via email:

Trinity University
Student Accessibility Services
1 Trinity Place San Antonio, TX 78212
Coates Library 308
Email: sas@trinity.edu
Fax: 210-999-8198

Authorization for Release of Information to Parent/Guardian

Parent/Guardian Name(s)___________________________________________________________
Address_________________________________________ Phone # __________________
I authorize Student Accessibility Services to discuss or release to the above parent/guardian information regarding my disability to assist in the determination and implementation of reasonable accommodations and to address educational planning needs.

I understand this authorization is voluntary. The authorization will remain in effect as long as I am a student at Trinity University or until I revoke the authorization. I understand I may revoke this consent at any time through a written, signed, and dated request to the Coordinator of Student Accessibility Services. The revocation will not apply to action taken prior to that date.

Student Signature ____________________________ Date ____________________________
**SAS Determination** (For Office Use Only)

Date of evaluation/diagnosis: ______________________

Date eligibility determined: __________ by: ________________________________

Disability: _________________________________________________________________________

Accommodations approved: ___________________________________________________________