Chronic Heath 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

☐ 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
- ☐ Anxiety
- ☐ Learning Disability
- ☐ Depression
- ☐ AD/HD
- ☐ Other accommodations or referrals. Please list._____

Evaluator Information

Evaluator Name:_____
Evaluator Title:_____
Evaluator Signature:_____
Address:_____
Phone Number:_____
Fax Number:_____
Email Address:_____