CONNECTICUT COLLEGE

Student Accessibility Services

Attention-Deficit/Hyperactivity Disorder Verification
Fillable Form*

The student named below has begun the process to request services with Student Accessibility Services (SAS) at Connecticut College. To determine eligibility and provide services, we require documentation of the student's disability.

Under the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities. A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodations. The documentation must also support the request for accommodations and academic adjustments.

Release of Information

I (print student name) _____
hereby authorize the release of the following information to the Student Accessibility Services at Connecticut College for the purpose of determining my eligibility for educational accommodations.

_____

Student Signature Camel ID # Date

Medical Provider Form

The following information is to be completed by a medical professional only.

Please give your provider ample time to complete the information requested.

Students upload the completed form to your AIM online portal.

*Text field will be displayed either next to or under the first word of the question or tab to the next field Note: Provider signature is not fillable. The document must be printed and signed by provider prior to submission.

Attention-Deficit/Hyperactivity Disorder Verification Form
To be completed by provider:

To the certifying professional:
Please complete the form below in as much detail as possible. The information you provide will not become part of the student's educational records. It will be kept in the student's file in SAS, where it will be held strictly confidential. This form may be released to the student at his/her/their request. In addition to the desired information below, please attach any other information you feel would be relevant to the student's request. Please contact SAS if there are any questions or concerns.

1.Student's Name Date

2. Diagnostic Code (ICD 10 or DSM V)

3. Level of Severity:

4. Date of Above Diagnosis:

5. Date Last Seen:

6. Please check all AD/HD symptoms listed that the student currently exhibits:
   A. Either (1) or (2)
      (1) **Inattention** (select all that apply)
      - ☐ fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities
      - ☐ has difficulty sustaining attention in tasks
      - ☐ does not seem to listen when spoken to directly
      - ☐ does not follow through on instructions and fails to finish schoolwork, chores or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
      - ☐ has difficulty organizing tasks and activities
      - ☐ avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort
      - ☐ loses things necessary for tasks or activities
      - ☐ easily distracted by extraneous stimuli
      - ☐ forgetful in daily activities

(2) **Hyperactivity-Impulsivity** (select all that apply)

- ☐ fidgets with hands, feet or squirms in seat
- ☐ leaves seat in classroom or in other situations where remaining seated is expected
- ☐ runs about or climbs excessively in situations in which it is inappropriate
- ☐ has difficulty playing or engaging in leisure activities quietly
- ☐ is "on the go" or acts as if "driven by a motor"
- ☐ talks excessively
- ☐ blurts out answers before questions have been completed
- ☐ has difficulty awaiting turn
- ☐ interrupts or intrudes on others

B. ☐ Several hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 12 years

C. ☐ Several impairments from the symptoms are present in two or more settings

D. ☐ There is clear evidence of clinically significant impairment in Social, Academic or Occupational Functioning

E. ☐ The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia or other Psychotic Disorder and are not better accounted for by another mental disorder.

7. Is the student currently prescribed medication(s)? Yes ☐ No ☐

If yes, please complete the following:

- Prescribed medication(s)
- By whom?
- Amount and frequency of administration
- Frequency of monitoring
- Response to medication
- How will refills be obtained?

8. Is there any indication this student may have an additional diagnosis, such as depression, anxiety, etc? ☐ Yes ☐ No If yes, please explain:

9. Have you recommended any type of therapy? ☐ Yes ☐ No If yes, what?

10. Please state the student's functional limitations based on the AD/HD diagnosis, specifically in a classroom or educational setting.

11. Please list any specific recommendations regarding this student's academic accommodations and a rationale for why these accommodations or services are warranted based on the student's functional limitations. Indicate why the accommodations are necessary.

12. Additional Information:

a. What other specific symptoms currently manifesting might impact the student's academic performance?

b. Is there anything else we should know about the student's disability?

Please attach any additional information you feel would be helpful

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CERTIFYING PROFESSIONAL*

Professional's Name: Title:

Name of Practice:

Address:

Phone: Email:

License # and Issuing State:

Signature of Professional: Date:

*Qualified diagnosing professionals are licensed psychologists, psychiatrists, neurologists, clinical social and counselors. The diagnosing professional must have expertise in the differential diagnosis of the documented mental disorder or condition and follow established practices in the fields.