



DISABILITY VERIFICATION FORM MEDICAL/MOBILITY

The diagnosing professional must be a physician or other medical specialist with experience and expertise in the area related to the student's disability. Form can be handwritten but please be clear and neat.

Student's Name:

Student's ID Number:

EVALUATION

Date of last evaluation

How did you get at this diagnose? Please check all relevant items below, add brief notes that you understand will help to determine eligibility for accommodations. (Specify dates of test's given)

- Structured or unstructured interviews with student
Behavioral observations
Interview with other person (parent, teacher, therapist)
Neuropsychological test (Attach copy document)
Medical evaluation (X-RAY, lab work, EKG, etc.)
MRI
Psychoeducational test (Attach copy document)
Other specify

Evaluation notes

Functional limitations: Yes No Describe if yes:

Please describe in detail any functional limitations that fall into the significant range.

Please list current medications and treatment history. Medication management Physical/Occupational therapy

Medication side effects:

Coexisting conditions: (provide details about any coexisting medical or psychiatric conditions, please include relevant reports)

Past accommodations: Yes No (please describe if yes)

Suggested accommodations: (please list specific academic accommodations you suggest based on your assessment of student clinical and academic history and diagnosis)

Severity of symptoms: Mild Moderate Severe

Prognosis of disorder: Mild Moderate Severe

The prognosis for the medical condition or disability above is:

Permanent/Chronic Long term: 6/12 months

Short term/Temporary: 6 months or less Expected duration: _____

Episodic (please describe below) _____

Please provide any additional information you feel useful in determining the nature and severity of the student's disability and (2) why each recommended accommodation is needed. Your recommendation should not be supported solely by a history of prior accommodation. You can prepare a narrative in a separate sheet of paper.

Functional Impact Assessment:

Please complete the following: Limitation is: 1= Unable to determine 2= Mild 3= Substantial

| 1 | 2 | 3 | Major Life Activity |
|---|---|---|-------------------------|
| | | | Caring for oneself |
| | | | Talking |
| | | | Hearing |
| | | | Breathing |
| | | | Seeing |
| | | | Walking/Standing |
| | | | Lifting/Carrying |
| | | | Sitting |
| | | | Performing manual tasks |
| | | | Eating |
| | | | Working |
| | | | Interacting with others |
| | | | Sleeping |

| 1 | 2 | 3 | Major Academic Activity |
|---|---|---|-------------------------|
| | | | Learning |
| | | | Reading |
| | | | Writing |
| | | | Spelling |
| | | | Calculating |
| | | | Concentrating |
| | | | Memorizing |
| | | | Listening |
| | | | Other: |
| | | | |
| | | | |
| | | | |
| | | | |

Examiner's Name and Title

Signature

License/Certification Number

Date