

Documentation Form for Health-Related Disability

This information submitted to Accessibility Services should reflect the most currently available information. **This Health-Related Disability Documentation Form should:**

- a) **Be completed by a qualified professional.**
- b) **Be completed as clearly and thoroughly as possible.** Incomplete responses and illegible handwriting may require additional follow up.
- c) **Be supplemented with reports or additional testing, if applicable.** Please do not provide case notes or rating scales without a narrative that explains the results.

Submit Information to:

Office of Accessibility Services

Glendening Hall 230
St. Mary's College of Maryland
47645 College Drive
St. Mary's City, MD 20686

FAX: 240-895-2234
PHONE: 240-895-2250

SMCM Student Name:

SMCM Student ID:

Date form is being completed:

1. Clinician's date of first contact with this student:
2. Clinician's date of last contact with this student:
3. List health conditions/disabilities including severity levels (e.g., mild, moderate, severe, profound):
4. Please check all applicable impacts/symptoms of this health-condition:

Low/High Blood Glucose
 Levels Anaphylaxis
 Hives/Rash
 Headaches
 Light Sensitivity
 Aural/Visual Field Disturbance
 Fainting
 Dizziness
 Brain Fog
 Urgent/Frequent Restroom Use

Seizures (Type:
 Muscle Weakness
 Nausea
 Vomiting
 Concentration/Attentional Difficulties
 Sleep Disturbance (Type:
 Pain (List Type & Location of Pain:

5. Please list any other impacts or symptoms that are not listed above:
6. What is the expected duration of the condition and its impact on the individual's daily functioning?

Permanent (more than 5 years)	Less than 1 year
1-5 years	Unknown

7. The condition is:

Stable	Improving	Worsening	Cyclically Variable
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- | | | |
|---|-----|----|
| i. Have there been any changes in the condition the last 12 months? | YES | NO |
| ii. Are any changes in the condition anticipated in the next 12 months? | YES | NO |

8. The prognosis is:

Poor

Fair

Good

Excellent

9. Treatment for this condition requires clinical follow-up/support:

Weekly

Monthly

Quarterly

Twice a year

Yearly

10. Discuss any side effects related to treatment or medications that may be relevant to identifying accommodations.

11. Please state any recommended **residential/dining** accommodations with a rationale.

12. Please state any recommended **academic** accommodations with a rationale.

13. Describe the **strategies and supports that have successfully worked** to address any limitations and why.

14. Please provide any additional information you feel is pertinent or may be of use in the accommodation process.

Provider Information

ProviderName (Print):

Provider Signature:

License or Certification #:

Address:

Phone:

FAX: