The Office of Student Accessibility Services

Medical Intake Form (Disability Documentation)

Medical Professional Must Be In Specialty Related to Disability and/or have expertise in area of Disability.

Section I: Completed By Student

Name: _____Date: __ Email:_____

Name of Medical Professional: _____

Medical Records Release

I, _____, hereby request and authorize the above-named healthcare professional to release my personal and medical information related to the requested accommodation to The Office of Student Accessibility Services (TJU/PU). I also authorize the above-named professional to verbally discuss any limitations related to my ability to participate in academic programs or related programs and services with a representative from The Office of Student Accessibility Services.

Student Signature _____
Date _____

Section II: Completed by Medical Professional

1. What is the name of the diagnosis/diagnoses?

2. What diagnostic criteria, evaluation methods, procedures or tests were used to reach this diagnosis?

3. How long has the student had this condition?

4. Please provide a brief history of the condition and recommended accommodations (if any)?

5. Is this condition permanent? If no, how long will it persist?

6. What are the symptoms or functional limitations of this condition (related to higher education)?

7. Does this condition limit a major life activity? A major life activity is an activity that the average person can perform with little or no difficulty (walking, seeing, hearing, speaking, breathing, learning, sitting, and standing). If yes, please specify the life activity and relate to functional limitations.

8. Please provide recommended accommodations in higher education. For each accommodation, you must provide a rationale, based on function limitation.

9. Is the student currently taking medication(s) related to the diagnosis for which accommodation is sought? If yes, list the medication(s), dosage, and any adverse side effects that impact the student's functioning (if any).

10. Please complete the following and sign below:

Print Name and Title _____

Area of Specialty _____

License # _____

Address: _____

Telephone _____ Fax _____ Email

Signature _____ Date _____

Please note that all information is confidential and is for the use of University staff