KALAMAZOO COLLEGE

Kalamazoo College Disability Information and Verification Form

Information and Instructions:
Kalamazoo College Disability Services provides accommodations for students with diagnosed disabilities. The documentation provided regarding the diagnosis must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.

In order to register with Disability Services, students are required to provide documentation from a qualified professional. Depending on the nature of a student's disability, qualified professionals could include a medical doctor, psychiatrist, or licensed psychologist. All documentation must be current (within the last three years) and relevant.

To facilitate the documentation process, Disability Services has provided this Disability Information and Verification form to be completed by the student (Section 1) and a qualified professional (Sections 2-3). As you complete the form and complete the other documentation, please note the following:

1. Thoroughly complete the form. Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification.

2. The qualified medical professional should attach any reports which provide information regarding the disability diagnosis (e.g. psychoeducational assessments, neuropsychological test results, etc.). **If a <u>comprehensive diagnostic report</u> is available that provides the requested information, copies of that report can be submitted for documentation in lieu of this form as long as the report addresses and answers the questions included in this form.**

3. Individualized Educational Programs (IEPs), 504 plans, and letters from qualified medical professional(s) may also be submitted but are **<u>not</u>** sufficient documentation without the completion of this form OR submission of comprehensive diagnostic reports.

4. Professionals conducting assessments, rendering diagnoses of a disability, and making recommendations for appropriate accommodations must be qualified to do so. The name, title and professional credentials of the evaluator, including information about licensure or certification (e.g., licensed psychologist) as well as the area of specialization, employment and state/province in which the individual practices should be clearly stated in the documentation. For example, the following professionals would generally be considered qualified to evaluate specific learning disabilities provided that they have additional training and experience in the assessment of learning problems in adolescents and adults: clinical or educational psychologists, school psychologists, neuropsychologists, or learning disabilities specialists. Use of diagnostic terminology indicating the disability by someone whose training and experience are not in these fields is not acceptable. It is not considered appropriate for professionals to evaluate members of their families. All reports must be on letterhead, typed, dated, signed and otherwise legible. Any documentation turned in that is illegible may impede a student from receiving accommodations.

The information that the student/caregiver provides, and all documentation will be kept in a student's confidential file in the Dean of Students Office. The information will only be disclosed with the student's permission or otherwise permitted or required by law. The student will have access to the information in the file.

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Please submit the signed and completed form and other documentation to:

Dana Jansma
Senior Associate Dean of Students

Mail: 1200 Academy Street
Office of Student Development
Kalamazoo, MI 49006

Fax: 269-337-7404

Email: dana.jansma@kzoo.edu
(PDF documents only)

If you have any questions regarding this form or documentation, please call Dean Jansma at 269-337-7209.

SECTION 1: STUDENT INFORMATION (to be completed by the student)

First Name: ________________________ MI: _____ Last: ____________________________________

Date of Birth: _________________________

Status (check one) _____current student _____admitted student

Cell Phone (domestic only): (_________) - ___________ - ________________

Campus Box (current student): _______________

Permanent Home Address: ____

____

K Email Address: __________________________________

Other Email Address: __________________________________

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SECTION 2: DIAGNOSTIC INFORMATION (to be completed by a qualified professional)
The College requests information relevant to the accommodation(s) being sought in this instance only. Information that is not relevant to this specific request is not necessary.

1. First date of contact with student: ______________________________
2. Last date of contact with student: ______________________________
3. Is the student currently under your care? _____Yes _____ No
4. Primary Diagnosis and Date of Diagnosis: ____

   ____

5. Secondary Diagnosis and Date of Diagnosis: ____

   ____

6. What is the severity of the condition? _____Mild _____Moderate _____Severe
7. Describe the symptoms that meet the criteria for this diagnosis. Please attach test results and diagnostic reports.
8. If applicable, describe relevant history of remediation (i.e. pharmacological, medical devices, etc. Include information about current medications and other treatment plans, including the effectiveness of such efforts and potential adverse side effects.
9. Describe the expected duration and/or progression of the disorder. If applicable, please include information about fluctuation of symptoms.

FOR DIAGNOSIS INVOLVING DSM-V MUTLI-AXIAL DIAGNOSIS

10. What is your DSM-V multi-axial diagnosis and ICD code(s) for this student?

Axis I	
Axis II	
Axis III	
Axis IV	
Axis V (GAF score)	
ICD Code(s)	

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11. In addition to the DSM-V criteria, how did you arrive at your diagnosis? Please check all relevant items below, adding brief notes you think might be helpful to use as we determine which accommodations and services are appropriate for the student.

_____ Structured or unstructured interviews with the student:

_____ Interview with other persons:

_____ Behavioral observations:

_____ Developmental history:

_____ Educational history:

_____Medical history:

_____Neuro-psychological testing, including name(s) and date(s) of testing:

_____ Psycho-psychological testing, including name(s) and date(s) of testing:

_____ Standardized or non-standardized rating scales:

_____ Other (please specify):

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12. To the extent possible, please provide information about how the student's condition may affect the student with respect to various life activities.

Life Activity	No Impact	Mild Impact	Moderate Impact	Severe Impact	Don't Know	N/A
Seeing						
Hearing						
Speaking						
Sitting						
Standing						
Walking						
Breathing						
Eating						
Sleeping						
Lifting						
Performing manual tasks						
Performing self-care tasks						
Learning						
Thinking						
Concentrating						
Managing external distractions						
Managing internal distractions						
Initiating to work (activating)						
Sustaining focus						
Remembering (memorizing)						
Managing stress						
Making/keeping appointments						
Submitting assignments in a timely manner						
Sensory functioning/integrating						
Attending class (regularly/on time)						
Understanding directions						
Communicating						
Social interactions						
Writing (manual writing)						
Writing (written expression)						
Reading (visually)						
Reading (comprehension)						

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13. In addition to those mentioned above, please describe if there are any other functional limitations of this condition for this student in an educational setting.

14. Describe any recommendations that you may have regarding academic accommodations or auxiliary aids for this student.

15. Describe whether there are particular situations or environmental conditions that would exacerbate the condition of the student's symptoms.

16. Please provide any other information that you think would be useful to know in working with the student to establish reasonable accommodations for their disability.

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Section 3: Qualified Provider Information

By signing below, you affirm that the above information is accurate to the best of your knowledge and provided in accordance with your best professional judgement.

Provider Signature: ____

Provider Name (Print): ____

Date: ____

Title: ____

License #: ____

Address: ____

Phone Number: ____

Email: ____