Graham Elementary School

Excellence in Everything We Do

Verification Form for Students with Psychological Disabilities and Attention-Deficit/Hyperactivity Disorder

Students seeking support services from Student Accessibility Services on the basis of a previously diagnosed psychological disability or Attention-Deficit/Hyperactivity Disorder (AD/HD) are requested to submit documentation that verifies their eligibility under Section 504 of the Rehabilitation Act, the Americans with Disabilities Act (ADA), and the ADA Amendments Act. The documentation should describe a disabling condition, which is defined by the presence of substantial limitations in one or more major life activities. This form is intended to guide the documentation process. Please contact us at (484) 258-2410 with any questions. It is the student's responsibility to ensure that Graham Elementary School Student Services receives this form or other appropriate documentation.

All documentation submitted is considered confidential.
Original copies of documentation will not be returned.

Student Information:

Name: _____ Date: _____
Student ID Number: _____
Phone: _____
Email: _____

Provider Information:

I certify, by my signature below, that I am not related to the student. My signature also certifies that I conducted, or formally supervised and co-signed, the diagnostic assessment of the student named above.

Signature: _____ Date: _____
Print Name and Title:_____
State of License: _____ License Number: _____
Address: _____
Street or P.O. Box City State Zip: _____
Phone: _____ Fax:_____

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The information below is to be completed by the Provider.

1. If available, please list all DSM-5 or ICD Diagnoses (text and code):

_____

_____

a. Date diagnosed: _____

b. Date of your last clinical contact with student: _____

2. Evaluation a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.

□ Structured or unstructured interviews with student.
□ Interviews with other persons (i.e., parent, teacher, therapist).
□ Behavioral observations.
□ Neuropsychological testing. Attach documentation.
□ Psychoeducational testing. Attach documentation.
□ Other (Please specify). _____

b. Current treatment being received by student:

□ Medication management: Current medications: _____
□ Outpatient therapy: Frequency: _____
□ Group therapy: Frequency: _____
□ Other (please describe): _____

c. Approximate age of onset: _____

d. Severity of symptoms

□ Mild □ Moderate □ Severe

e. Prognosis of disorder:

□ Good □ Fair □ Poor

Please explain:

_____

_____

3. Functional Limitations

a. Does this condition significantly limit one or more of the following major life activities?

	No Impact	Moderate Impact	Substantial Impact	Don't Know
Communicating				
Concentrating				
Hearing				
Learning				
Manual Tasks				
Reading				
Seeing				
Thinking				
Walking				
Working				
Other:				

For the purpose of establishing reasonable accommodations, please provide any additional information you feel may be useful for us to know about the student's disability, if applicable:

b. Please check the current functional limitations or behavioral manifestations for this student:

	No Issue	Moderate Issue	Substantial Issue	Don't Know
Cognitive Processing				
Memory				
Processing Speed				
Meeting Deadlines				
Attending Class				
Organization				
Reasoning				
Stress				
Sleep				
Appetite				
Other:				

For the purpose of establishing reasonable accommodations, please provide any additional information you feel may be useful for us to know about the student's disability, if applicable:

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