**PART I TO BE COMPLETED BY EVALUATOR**

**DISABILITY SERVICES – LOUISIANA STATE UNIVERSITY**

# ATTENTION DEFICIT/HYPERACTIVITY DISORDER (ADHD) DOCUMENTATION REQUEST FORM

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did/will you start attending LSU? Semester\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LSU I.D. Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LSU Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This student is requesting an auxiliary aid or service, academic adjustment, and/or other accommodations from Disability Services. In order to consider this request, as well as to ensure the provision of reasonable and appropriate auxiliary aids and services, university policy requires that a **qualified professional** provide current and comprehensive documentation of ADHD. A qualified professional includes a licensed psychiatrist, psychologist, medical doctor, or other qualified mental health professional **who is not a family member of the student**.

## \*\*\*\* This form must contain ALL of the requested information below in order to apply for accommodations through Disability Services. \*\*\*\*

1. Diagnosis (as diagnosed by the DSM-5): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If you have a formal evaluation, please attach it.

1. Date of Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Contact with Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Provide a summary of the student’s educational, medical, and family history that may relate to ADHD (must demonstrate that difficulties are not the result of other conditions, cultural differences, or insufficient instruction):

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1. Describe the student’s functional limitations (i.e., current and/or anticipated problems associated with the condition) in an educational setting.

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1. List **current medication**, along with any **current side effects** that may impact academic performance:

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1. Please indicate below the **RECOMMENDATIONS** you have regarding necessary and appropriate auxiliary aids or services or other accommodations to equalize the student’s educational opportunities at LSU as justified based on the functional limitations indicated above.

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Qualified Professional’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name & Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

License or Certification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daytime Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Disability Services**

**Louisiana State University**

**124 Johnston Hall**

**Baton Rouge, LA 70803**

**Phone: 225-578-5919**

**Fax: 225-578-4560**

**Email:disability@lsu.edu**

**PART II TO BE COMPLETED BY STUDENT**

**DISABILITY SERVICES – LOUISIANA STATE UNIVERSITY**

# REQUEST FOR ACCOMMODATIONS

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did/will you start attending LSU? Semester\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LSU I.D. Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LSU Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LSU enrollment for which you are requesting accommodations (check below):

LSU A&M (Main Campus) LSU Law Center Vet School LSU Online

Independent and Distance Learning (Enrollment #) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I am requesting accommodations because I have been diagnosed with one or more of the following disabilities which functionally impairs my ability to perform in an academic environment (check all that apply):**

 Attention Deficit Hyperactivity Disorder (ADHD)

 Learning Disability

 Deaf & Hard of Hearing

 Psychological Disability (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Physical or Medical Disability (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Temporary Disability (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In the space below, please list and explain the reason for each of the accommodations you are requesting.**

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## Signature of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Please note: Disability Services strongly recommends maintaining copies of any submitted documentation for personal records.**

# CONSENT TO RELEASE

I**, *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(student/incoming student)*,** understand that the

information contained in my record is confidential. However, I give my consent for

## DISABILITY SERVICES

to release to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***(parent, guardian, other)***

the following specific information: **DISABILITY AND ACADEMIC**

The above-listed information is to be disclosed for the specific purpose of

**ACCOMMODATIONS and UNIVERSITY SUPPORTS**.

This consent is subject to writtenrevocation OR cancellation signature at any time except to the extent that action has already been taken upon this consent. All releases are done on roughly an annual basis regardless of any date changes to the form with all releases expiring at the end of the upcoming academic year.

This consent will automatically expire **AUGUST 20, 2020**.

Footer with address of LSU

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

Signature of Student/Client

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

LSU ID#

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**I wish to cancel this Consent to Release effective** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Student/Client