RIDER UNIVERSITY

Accommodations ▪ Coaching ▪ Consultation

Student Accessibility and Support Services
Joseph P. Vona Academic Annex
2083 Lawrenceville Road
Lawrenceville, NJ 08648-3099
T 609-895-5492
F 609-895-5507
accessibility@rider.edu
www.rider.edu/sass

Documentation of Chronic Medical or Health Disability

Confidential

TO BE COMPLETED BY STUDENT:

I hereby authorize _____ to

Release to and discuss with the Rider Student Accessibility and Support Services Office the information specified below.

Signature:_____ Date:_____

TO BE COMPLETED BY PROFESSIONAL:

To ensure the provision of reasonable and appropriate accommodations for students with chronic medical or health disabilities at Rider University, **this form must be completed by a licensed medical professional (e.g. physician, orthopedist, gastrologist)**.

Name of Student:_____ Date of Birth:_____

Diagnosis:_____

_____

Date of original diagnosis:_____ Date student was last seen:_____

1) Please provide the following:

Date of most current evaluation:_____

Diagnostic criteria used:_____

_____

Date and/or age of onset medical or health disability: _____

_____

Nature of the medical disability (please circle):

Stable Variable Progressive

Student's Name: _____

The definition of disability according to the ADAA (Americans with Disabilities Act as Amended) is as follows:

"A physical or mental impairment that substantially limits one or more major life activities"

2) Please check the "major life activity/ties" the disability substantially limits:

- ☐ Caring for oneself
- ☐ Hearing
- ☐ Walking
- ☐ Bending
- ☐ Learning
- ☐ Thinking
- ☐ Performing manual tasks
- ☐ Eating
- ☐ Standing
- ☐ Speaking
- ☐ Reading
- ☐ Communicating
- ☐ Seeing
- ☐ Sleeping
- ☐ Lifting
- ☐ Breathing
- ☐ Concentrating

3) Please indicate student's current symptoms, likely impact on academic functioning in a college setting, and recommended academic accommodations:

Symptoms: _____

_____

_____

_____

_____

_____

Functional Limitations: _____

_____

_____

_____

_____

_____

_____

Recommended Academic Accommodations: _____

_____

_____

_____

4) Please identify any treatment in which the student is currently involved.

5) Please list all currently prescribed medication and any side effects which may impact the student's academic functioning or any other area of the student's college life.

6) What other information do you consider relevant to this student's ability to succeed in a college setting?

_____

_____

_____

7) Please attach all relevant assessment data (including results of medical tests and other evaluations).

Signature: _____

Print Name and Title: _____

License # _____

Agency Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

PLEASE MAIL, EMAIL, or FAX COMPLETED FORM TO:

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