



***Disability Support Services***  
***940-397-4140***  
***FAX: 940-397-4180***

## **ADD / ADHD Verification Form**

Disability Services Service (DDS) provides academic services and accommodations for students with diagnosed disabilities. The documentation provided regarding the disability 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 addition, in order for a student to be considered eligible to receive academic accommodations, the documentation must show functional limitations that impact the individual in the academic setting.

DDS requires current and comprehensive documentation in order to determine appropriate services and accommodations. The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional(s) in obtaining the specific information necessary to evaluate eligibility for academic accommodations.

**A. The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so.** These persons are generally trained, certified or licensed psychologists or members of a medical specialty.

**B. All parts of the form must be completed as thoroughly as possible.** Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification. ***It is recommended that this form be completed by typing the information into the editable PDF version of the form available on our website at <http://students.mwsu.edu/disability/>***

**C. The healthcare provider should attach any reports which provide additional related information** (e.g. psycho-educational testing, neuropsychological test results, etc.). If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form. *Please do not provide case notes or rating scales without a narrative that explains the results.*

**D. After completing this form, sign it, complete the Healthcare Provider Information section on the last page and mail or fax it to us at the address provided in our letterhead.** The information you provide will *not* become part of the student's educational records, but it will be kept in the student's file at DDS, where it will be held strictly confidential. This form may be released to the student at his/her request. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment. If you have questions regarding this form, please call the DDS office at 940-397-4140. Thank you for your assistance.

**STUDENT INFORMATION**  
**(Please Print Legibly or Type)**

Name (Last, First, Middle): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Last 4 Digits of SSN: \_\_\_\_\_

Status (check one):  current student  transfer student  prospective student

Local phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Cell phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_

Address (street, city, state and zip code): \_\_\_\_\_

\_\_\_\_\_

**DIAGNOSTIC INFORMATION**  
**(Please Print Legibly or Type)**

*Please provide responses to the following items by typing or writing in a legible fashion. Illegible forms will delay the documentation review process for the student.*

1. DSM-IV diagnosis:

- 314.00
- Predominantly Inattentive
- Predominantly Hyperactive-Impulsive
- 314.01 Combined type
- 314.9 Not otherwise specified

2. In addition to DSM-IV criteria, how did you arrive at your diagnosis?

- Behavioral observations
- Developmental history
- Rating scales
- Medical history
- Structured or unstructured clinical interview with the student
- Interviews with other persons
- Neuropsychological testing (dates of testing)  
(Please attach diagnostic report of testing)
- Other (Please specify)

3. Please state date of diagnosis: \_\_\_\_\_

4. What is the severity of the condition? Please check one:  
\_\_mild      \_\_moderate      \_\_severe

Explain severity:

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State the following:

a. date of first contact with student: \_\_\_\_\_

b. date of last contact with student: \_\_\_\_\_

5. Student's History:

a) **ADHD History:** Evidence of inattention and/or hyperactivity during childhood and presence of symptoms prior to age seven. Provide information supporting the diagnosis obtained from the student/parents/and teachers. Indicate the ADHD symptoms that were present during early school years (e.g. daydreamer, spoke out of turn, unable to sit still, difficulty following directions, etc.)

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b) **Psychosocial History:** Provide relevant information obtained from the student/parent(s)/guardian(s) regarding the student's psychosocial history (e.g. often engaged in verbal or physical confrontation, history of not sustaining relationships, history of employment difficulties, history of educational difficulties, history of risk-taking or dangerous activities, history of impulsive behaviors, social inappropriateness, history of psychological treatment, etc.).

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c) **Pharmacological History:** Provide relevant pharmacological history including an explanation of the extent to which the medication has mitigated the symptoms of the disorder in the past. Also include any *current medication(s)* that the student's currently prescribed including dosage, frequency of use, the adverse side effects, and the effectiveness of the medication.

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d) **Educational History:** Provide a history of the use of any educational accommodations and services related to this disability.

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6. Student's Current Specific Symptoms

Please check all ADHD symptoms listed in the DSM-IV that the student *currently* exhibits:

**Inattention:**

- often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities.
- often has difficulty sustaining attention in tasks or play activities.
- often does not seem to listen when spoken to directly.
- often does not follow through on instructions and details to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions).
- often has difficulty organizing tasks and activities.

- often avoids, dislikes, or is reluctant to engage in tasks (such as schoolwork or homework) that require sustained mental effort.
- often loses things necessary for tasks or activities (e.g. school assignments, pencils, books, tools, etc.)
- is often easily distracted by extraneous stimuli.
- often forgetful in daily activities.

**Hyperactivity:**

- often fidgets with hands or feet or squirms in seat
- often leaves (or greatly feels the need to leave) seat in classroom or in other situations in which remaining seated is expected.
- often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness).
- often has difficulty playing or engaging in leisure activities that are more sedate.
- is often “on the go” or often acts as if “driven by a motor”.
- often talks excessively.

**Impulsivity**

- often blurts out answers before questions have been completed
- often has difficulty waiting turn
- often interrupts or intrudes on others (e.g. butts into conversations or games).

7. State the student’s *functional limitations* based on the ADHD diagnosis, specifically in a classroom or educational setting.

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8. State specific recommendations regarding academic accommodations for this student, and a rationale as to why these accommodations/services are warranted based upon the student’s functional limitations. Indicate why the accommodations are necessary (e.g. if a note taker is suggested, state the reasons for this request related to the student’s diagnosis).

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9. If current treatments (e.g. medications, counseling, etc.) are successful, state the reasons why the above academic adjustments/accommodations/services are necessary. Please be specific.

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**HEALTHCARE PROVIDER INFORMATION**

**(Please sign & date below and fill in all other fields completely using PRINT or TYPE)**

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Provider Name (Print):** \_\_\_\_\_

**Title:** \_\_\_\_\_

**License or Certification #:** \_\_\_\_\_

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

\_\_\_\_\_

**Phone Number:** (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_

**FAX Number:** (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_

**Important: After documentation is reviewed, DDS will call or send an email notification to the students acknowledging receipt of documentation and the eligibility status.**