

SDSM&T COUNSELING AND STUDENT ADA SERVICES

VERIFICATION OF A MEDICAL DISABILITY

Counseling and Student ADA Services provides services to students with medical disabilities. To determine eligibility for services and appropriate accommodations, this office requires **current and comprehensive** documentation of the medical condition from the **diagnosing physician currently treating the student**.

Please answer the following questions pertaining to:

Name: _____

Date of Birth: _____

1. Diagnosis: _____

2. Date of Diagnosis: _____

3. Last contact with the student: _____

4. Is the student/patient currently under your care? _____

5. List current medication(s), impact, and adverse side effects.

6. If the student is currently undergoing medical treatment, please describe and indicate how the treatment might affect the student academically.

7. Please describe how this medical condition may result in specific functional limitations in an academic setting (i.e., problems sitting for long periods of time, unable to type for more than ten minutes, or unable to walk more than 50 feet without fatigue)?

8. Are there any situations or environmental conditions that might lead to an exacerbation of the condition?

9. Major Life Activities Assessment:

Please check which of the following major life activities listed below are affected because of the impairment. Indicate severity of limitations.

Life Activity	1-Negligible	2-Moderate	3-Substantial
Talking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caring for Oneself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Performing Manual Tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memorizing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interacting with Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature: _____ Date: _____

Print name, title, and License#: _____

Address: _____

Telephone: _____

Return this information to the above address to the attention of:

Ms. Megan Reder-Schopp, MS, LPC, NCC

Director of Counseling and Student ADA Services

SDSM&T

501 E. St. Joseph St.

Rapid City, SD 57701

Or fax to 605-394-2914