ADHD Disability Verification Form

To Be Completed by Psychiatrist/Psychologist/or Diagnosing Physician

Eligibility requirements for support services for students with Attention Deficit/Hyperactivity Disorder:

1. Student provides verification of diagnosis and severity.
2. Student is assessed as having a functional limitation in the educational setting.

To ensure the provisions of reasonable and appropriate services for students with Attention Deficit/Hyperactivity Disorder at Northern Vermont University, students needing such services are required to provide current and comprehensive documentation of their disability. This documentation should include information on the diagnosis, describe the attention difficulties and the functional limitations in an educational setting, indicate the severity and longevity of the condition, and offer recommendations for treatment. To facilitate the gathering of such critical information, we ask that you respond to the following questions.

Please provide the following information about:

Student's DoB: _____

1. DSM – 5 Diagnosis: _____

2. Level of Severity: Mild _____ Moderate _____ Severe _____

3. Date of Diagnosis: _____Last contact with student: _____

4. What procedures were used to assess/diagnose ADHD? (Please attach a diagnostic report)

5. Describe Student's symptoms which meet the criteria for this diagnosis with approximate date of onset for each: _____
   _____
   _____
   _____
   _____

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6. Describe Student's functional limitations in an educational setting:_____
   _____
   _____
7. What measures were used to assess Student's current educational achievement?
   _____
   _____

_____
_____

8. What recommendations, if any, do you have regarding effective academic accommodations to equalize Student's educational opportunities at the post-secondary level?
_____
_____
_____
_____

9. Please indicate what medication, if any, has been prescribed for Student to treat Student's ADHD: _____
_____

10. In addition to the diagnostic report, please attach any other information you consider relevant to Student's post-secondary success.

X _____

Signature of Diagnosing Physician

Print Name and Title:

Address:
Telephone: email:

Please return this form and supporting materials to the Coordinator of Disability Services

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