BARD COLLEGE AT
SIMON'S ROCK
THE EARLY COLLEGE

Documentation of Attention-Deficit/Hyperactivity Disorder (AD/HD)

A student at Bard College at Simon's Rock is requesting accommodations under the Americans with Disabilities Act on the basis of Attention-Deficit/Hyperactivity Disorder (AD/HD). This office requires current and comprehensive documentation of the student's disorder from a qualified evaluator. The following professionals generally would be considered qualified to evaluate and diagnose AD/HD: licensed psychologists, neuropsychologists, psychiatrists, and other relevantly trained medical doctors. T**he provider completing this form cannot be a relative of the student**. Specific information concerning the student's condition and its impact on learning must be provided. **Please fill out the form completely.** Any questions should be directed to Jean Altshuler, Interim Disability and Academic Support Services Specialist at Bard College at Simon's Rock at 413.528.7383 or jaltshuler@simons-rock.edu

STUDENT'S NAME: _____

Please respond to the following items regarding the student named above **(Please print or type)**:_____

1. What is the student's DSM IV-TR diagnosis? _____

   a. State the student's current symptoms that meet the criteria for this diagnosis.

   _____

   _____

   _____

   b. State the age of onset of symptoms described by DSM IV-TR. _____

   c. What is the severity of the condition? _____

   d. State the frequency of your appointments and the date of your last contact with this student.

   _____

2. Describe the differential diagnoses that were excluded. State your reasons for considering these diagnoses, and your reasons for ruling them out. _____

_____

_____

_____

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3. List and describe the measures used to support the student's diagnosis. Neuropsychological or psychoeducational assessment is important in determining the **current** impact of the disorder on the individual's ability to function in academically related settings. (Please attach report if available.)

_____

_____

_____

_____

4. Describe the symptoms related to the student's condition that cause **significant** impairment in a major life activity.

_____

_____

_____

_____

_____

5. List the student's current medication(s), dosage, frequency, and adverse side effects.

_____

_____

_____

a. Are there significant limitations to the student's functioning directly related to the prescribed medications? YES _____ NO _____

b. If YES, please describe. _____

_____

_____

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6. Please state specific recommendations regarding accommodations for this student, and a rationale as to why these accommodations are warranted based upon the student's functional limitations.

_____

_____

_____

_____

8. If current treatments (e.g., medications) are successful, why are the above accommodations necessary?

_____

_____

_____

_____

_____

Certifying Qualified Evaluator (Cannot be a relative of student):

License #: _____ State: _____

Name: _____ Phone #: _____

Address:_____

Email: _____

Signature of Provider: _____ Date: _____

ALL DOCUMENTATION WILL BE HELD IN THE STRICTEST CONFIDENCE

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**Guidelines adapted from text created by Polly Waldman