ST MARY'S COLLEGE of MARYLAND
The National Public Honors College

OFFICE OF ACCESSIBILITY SERVICES
47645 College Drive
St. Mary's City, MD 20686

www.smcm.edu
TEL: 240-895-2250
FAX: 240-895-2234

Documentation Form for Health-Related Disability

The information submitted to the Office of Accessibility Services should reflect the most current available information. This Health-Related Disability Documentation Form should:

a) **Be completed by a qualified professional.**
b) **Be completed as clearly and thoroughly as possible**. Incomplete or illegible responses may require further follow-up.
c) **Be supplemented by relevant supporting documentation, such as psycho-educational or neuropsychological reports, if applicable.** Please avoid submitting case notes or rating scales without an accompanying narrative that explains the findings.

Submit information to:

Office of Accessibility Services

Glendening Hall 253 & 254
St. Mary's College of Maryland
47645 College Drive
St. Mary's City, MD, 20686

Fax: 240-895-2234
Phone: 240-895-2250
Email: adasupport@smcm.edu

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SMCM Student Name: SMCM Student ID:

Date form is being completed:

1. Clinician's date of first contact with student:

2. Clinician's date of last contact with student:

3. List health conditions/disabilities including severity levels (e.g., mild, moderate, severe, profound):

4. Please check all applicable impacts/symptoms of this health condition:

- ☐ Low/High blood glucose
- ☐ Anaphylaxis
- ☐ Hives/rash
- ☐ Headaches
- ☐ Light sensitivity
- ☐ Aural/visual field disturbance
- ☐ Fainting
- ☐ Brain fog
- ☐ Pain – list type and location:
- ☐ Seizures – type:
- ☐ Muscle weakness
- ☐ Nausea
- ☐ Vomiting
- ☐ Concentration/attention difficulties
- ☐ Sleep disturbance – type:
- ☐ Dizziness
- ☐ Urgent/frequent restroom use

5. Please list any other impacts or symptoms that are not listed above:

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6. What is the expected duration of the condition and its impact on the individual's daily functioning?

☐ Permanent (more than 5 years) ☐ Less than 1 year

☐ 1-5 years ☐ Unknown

7. The condition is:

☐ Stable ☐ Improving ☐ Worsening ☐ Cyclically variable

i. Have there been any changes in the condition over the past 12 months?

☐ Yes ☐ No

ii. Are any changes in the condition expected in the next 12 months?

☐ Yes ☐ No

8. The prognosis is:

☐ Poor ☐ Fair ☐ Good ☐ Excellent

9. Treatment for this condition requires clinical follow-up/support:

☐ Weekly ☐ Monthly ☐ Quarterly ☐ Twice a year ☐ Yearly

10. Describe any **side effects related to treatment or medication** that may be relevant when identifying accommodations.

11. Describe any **recommended residential/dining accommodations** and provide rationale.

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12. Describe any **recommended academic accommodations** and provide rationale.

13. Describe the **strategies and supports that have successfully worked** to address any limitations and why.

14. Provide any additional information you feel is pertinent or may be of use in identifying appropriate accommodations.

Provider information

Provider name (please print):

Provider signature:

License or Certification #:

Address:

Phone: Fax: