Chronic Health Conditions Documentation Form

Student Name: ____________________________________ DOB: ___/___/______ has requested disability support services from the Office of Disability Services for Students (DSS) at Indiana University Bloomington (IUB) in regard to a chronic health condition. Documentation provides vital information about the functional limitation of the student’s disability and its impact in a post-secondary academic environment.

There are a variety of health conditions that may affect a student's academic functioning while in college. Examples of chronic health disorders include, but are not limited to: Crohn’s disease, cystic fibrosis, Ehlers-Danlos Syndrome, diabetes, Lyme disease, or rheumatoid arthritis.

Please complete all sections of this form and return it as soon as possible so that we may verify the student’s eligibility for services. Providers may also use their own documentation format as long as all of the information requested below is included; if this information is not provided, services may be delayed as DSS obtains clarification. Please call 812-855-7578 if you have questions. The completed form may be faxed to 812-855-7650 or it may be mailed to the address at the bottom of this page. DSS welcomes any additional documentation you would like to include.

Diagnoses:
Primary: __________________________________________
Secondary: __________________________________________
Date of Diagnosis: ___/___/______ Initial visit: ___/___/______ Last appointment: ___/___/______

Basis on which Diagnosis was made:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Clinical Manifestations or Current Symptoms:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Characteristics of Neurological Condition: (Check all Appropriate Terms)
☐ Stable ☐ Slow Progressing ☐ Rapid Progressing ☐ Improving ☐ Mild ☐ Moderate ☐ Severe

Current medical treatment that may affect the student in the higher education environment.
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Do the student’s symptoms fluctuate or worsen ☐ Yes ☐ No If yes, please explain:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
How long do you anticipate the condition impacting academic achievement? (Check one)

☐ < 6 months  ☐ < 1 year  ☐ > 1 year

Prescribed medication and the side effects that impact academic functioning:

__________________________________________________________________________________________

Implications for Educational Success/Major Life Activities (REQUIRED):

Please check which of the major life activities listed below are affected because of the diagnosis.

Substantial limitation is defined as a “significant restriction in the condition, manner, or duration in which a major life activity is performed compared to most people.”

☐ Concentration*  ☐ Fine Motor Skills  ☐ Communication
☐ Memory*  ☐ Stress Management  ☐ Eating
☐ Sleeping  ☐ Walking  ☐ Lifting
☐ Other ____________  ☐ Other ______________  ☐ Other ____________

*Note: Appropriate psychometric data should be included for these areas of limitation.

Additional comments and recommended auxiliary support, strategies, or service that may be beneficial to the student in the higher education environment.

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Certifying Professional

Name (print): ____________________________________________ Date: _____ / ____ / ____
Profession: ___________________________ License number: ___________________________
Office Address: ___________________________
Phone: ____________________ Fax: ____________________ Email Address: ____________________

Certifying Professional Signature: ____________________________________________