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 regards to a chronic health condition. To be eligible for disability support, IUB guidelines require that students requesting such assistance provide documentation of the condition and how it impacts his/her ability to learn.

The Americans with Disabilities Act as Amended and Section 504 of the Rehabilitation Act of 1973 protect individuals with disabilities from discrimination and entitle these individuals to reasonable accommodations. To establish that an individual is protected under the law, documentation must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities and have an expected duration of not less than 6 months. A diagnosis in and of itself does not automatically qualify an individual for accommodations. The documentation must also support the request for accommodations and academic impact.

Professionals recommended to provide documentation include general physicians and specialty physicians such as rheumatologists, oncologists, cardiologists, and neurologists.

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.

Diagnosis:
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Date of Diagnosis: ______/_____/_____

Basis on which Diagnosis was made:
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Clinical Manifestations/Symptoms:
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Characteristics of Health Condition(s): (Check all Appropriate Terms)
☐ Permanent  ☐ Temporary  ☐ Stable  ☐ Slow Progression  ☐ Rapid Progression  ☐ Improving
Can the condition(s) be mitigated by treatment? □ Yes □ No

Are you providing treatment? □ Yes □ No

If no, please explain: ______________________________________________________________

If yes, is the student following the treatment plan? □ Yes □ No

Frequency of visits, including patient’s last appointment:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Does the student experience fluctuations in symptoms? □ Yes □ No

Estimated frequency and duration of exacerbations:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

What factors, if any, contribute to the onset of worsening symptoms?
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Explain how the student will be affected or limited by the condition in an academic environment:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

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:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Long-term prognosis and treatment plan:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Certifying Professional
Name (print): _________________________________________________________ Date: ____ / ____ / _____
Profession: _____________________________________________ License number: _____________________
Office Address: _____________________________________________________________________________
Phone: ______________________ Fax: ______________________  Email Address: _____________________
Certifying Professional Signature: _____________________________________________________________