

PART I TO BE COMPLETED BY EVALUATOR

DISABILITY SERVICES – LOUISIANA STATE UNIVERSITY

**PHYSICAL AND MEDICAL DISABILITY DOCUMENTATION REQUEST
FORM**

Student's Name: _____

Phone Number: _____ Date of Birth: _____

When did/will you start attending LSU? Semester _____ Year: _____

LSU I.D. Number: _____ LSU Email: _____

This student is requesting an auxiliary aid or service, academic adjustment, and/or other accommodations from Disability Services. In order to consider this request, as well as to ensure the provision of reasonable and appropriate auxiliary aids and services, university policy requires that a **qualified professional** provide current and comprehensive documentation. A qualified professional includes a licensed medical doctor or other qualified healthcare professional **who is not a family member of the student.**

- If it is a **visual disability**, the documentation must include the student's visual acuity (best corrected), a description of the effects of the visual problems, and a recommended font size for text when enlarged text is recommended as an accommodation.
- In addition to completing the form below, an audiogram completed by a licensed audiologist must also be submitted for students who are **deaf or hard of hearing.**

****** This form must contain ALL of the requested information below in order to apply for accommodations through Disability Services. ******

1. Diagnosis: _____

2. Date of Diagnosis: _____ Date of Last Contact with Student: _____

3. Provide a summary of the student's educational, medical, and family history that relates to the physical or medical disability (must demonstrate difficulties are not the result of other conditions, cultural differences, or insufficient instruction): _____

4. Describe the student's functional limitations (i.e., current and/or anticipated problems associated with the condition) in an educational setting: _____

5. List **current medication**, along with any **current side effects** that may impact academic performance: _____

6. Please indicate below the **RECOMMENDATIONS** you have regarding necessary and appropriate auxiliary aids or services or other accommodations to equalize the student's educational opportunities at LSU as justified based on the functional limitations indicated above.

Qualified Professional's Signature: _____

Printed Name & Title: _____

License or Certification Number: _____

Daytime Telephone Number: _____

Address: _____

Date: _____

Disability Services
Louisiana State University
124 Johnston Hall
Baton Rouge, LA 70803
Phone: 225-578-5919
Fax: 225-578-4560
Email: disability@lsu.edu

PART II TO BE COMPLETED BY STUDENT
DISABILITY SERVICES – LOUISIANA STATE UNIVERSITY
REQUEST FOR ACCOMMODATIONS

Student's Name: _____

Phone Number: _____ Date of Birth: _____

When did/will you start attending LSU? Semester _____ Year: _____

LSU I.D. Number: _____ LSU Email: _____

LSU enrollment for which you are requesting accommodations (check below):

LSU A&M (Main Campus) LSU Law Center Vet School LSU Online
Independent and Distance Learning (Enrollment #) _____

I am requesting accommodations because I have been diagnosed with one or more of the following disabilities which functionally impairs my ability to perform in an academic environment (check all that apply):

- Attention Deficit Hyperactivity Disorder (ADHD)
- Learning Disability
- Deaf & Hard of Hearing
- Psychological Disability (specify): _____
- Physical or Medical Disability (specify): _____
- Temporary Disability (specify): _____

In the space below, please list and explain the reason for each of the accommodations you are requesting.

Signature of Student: _____ **Date:** _____

***Please note: Disability Services strongly recommends maintaining copies of any submitted documentation for personal records.**



Division of Student Affairs
Disability Services

CONSENT TO RELEASE

I, _____ (*student/incoming student*), understand that the information contained in my record is confidential. However, I give my consent for

DISABILITY SERVICES

to release to _____ (*parent, guardian, other*)

the following specific information: **DISABILITY AND ACADEMIC**

The above-listed information is to be disclosed for the specific purpose of

ACCOMMODATIONS and UNIVERSITY SUPPORTS.

This consent is subject to written revocation OR cancellation signature at any time except to the extent that action has already been taken upon this consent. All releases are done on roughly an annual basis regardless of any date changes to the form with all releases expiring at the end of the upcoming academic year.

This consent will automatically expire **AUGUST 31, 2022.**

Signature of Student/Client

LSU ID#

Date

I wish to cancel this Consent to Release effective _____
Date

Signature of Student/Client