PART I
TO BE COMPLETED BY EVALUATOR

DISABILITY SERVICES – LOUISIANA STATE UNIVERSITY

ATTENTION DEFICIT/HYPERACTIVITY DISORDER (ADHD) 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 of ADHD. A qualified professional includes a licensed psychiatrist, psychologist, medical doctor, or other qualified mental health professional who is not a family member of the student.

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

1. Diagnosis (as diagnosed by the DSM-5): ____________________________________________________________________________

2. If you have a formal evaluation, please attach it.

3. Date of Diagnosis: ______________ Date of Last Contact with Student: ______________

4. Provide a summary of the student’s educational, medical, and family history that may relate to ADHD (must demonstrate that difficulties are not the result of other conditions, cultural differences, or insufficient instruction):

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

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

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

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

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

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7. 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.

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____________________________________________________________________________________________

Qualified Professional’s Signature: ____________________________

Printed Name & Title: ____________________________

License or Certification Number: ____________________________

Daytime Telephone Number: ____________________________

Address: ____________________________

Date: ____________________________

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Disability Services
Louisiana State University
124 Johnston Hall
Baton Rouge, LA 70803
Phone: 225-578-5919
Fax: 225-578-4560
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 E-mail: _______________________________________

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.

___________________________________________________________________________________________

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Signature of Student: _______________________________ Date: _______________________________

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