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):

_____

_____

_____

_____

_____

_____

_____

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:

_____

_____

_____

_____

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.

_____

_____

_____

_____

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 20, 2021**.

_____
Signature of Student/Client

_____
LSU ID#

_____
Date

I wish to cancel this Consent to Release effective _____.
Date

_____
Signature of Student/Client

Louisiana State University
124 Johnston Hall
Baton Rouge, LA 70803

O 225-578-5919
F 225-578-4560
lsu.edu/disability