UNION
COLLEGE
FOUNDED 1795

Union College Certification of Attention-Deficit/Hyperactivity Disorder

The student named below has begun the process to request services with the Accommodative Services Office (ASO) at Union College. To determine eligibility and provide services, we require documentation of the student's disability.

Under the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities. A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodations. The documentation must also support the request for accommodations and academic adjustments.

Release of Information

I, (student print name) _____, hereby authorize the release of the following information to the Accommodative Services Office at Union College for the purposes of determining my eligibility for educational accommodations.

_____	_____	_____
Student Signature	Student ID #	Today's Date

Attention-Deficit/ Hyperactivity Disorder Verification Form

To the certifying professional:

Please complete the form below in as much detail as possible. Email, or mail it directly to the Accommodative Services Office (ASO) using our contact information at the bottom of the page. The information you provide will not become part of the student's educational records. It will be kept in the student's file in the ASO, where it will be held strictly confidential. This form may be released to the student at his/her/their request. In addition to the desired information below, please attach any additional information you feel would be relevant to the student's adjustment in the academic environment. Please contact the ASO if there are any questions or concerns.

1. Student's Name:_____Date:_____

2. Diagnostic Code (ICD 10 or DSMV)_____

3. Level of Severity: _____

4. Date of Above Diagnosis: _____

5. Date Last Seen: _____

6. Please check all ADHD symptoms listed that the student currently exhibits:

A. Either (1) or (2) or both

☐ (1) Inattention (select all that apply)

- ☐ fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities
- ☐ has difficulty sustaining attention in tasks or play activities
- ☐ does not seem to listen when spoken to directly
- ☐ does not follow through on instructions and fails to finish schoolwork, chores or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
- ☐ has difficulty organizing tasks and activities
- ☐ avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort
- ☐ loses things necessary for tasks or activities
- ☐ easily distracted by extraneous stimuli
- ☐ forgetful in daily activities

☐ (2) Hyperactivity-Impulsivity (select all that apply)

- ☐ fidgets with hands, feet or squirms in seat,
- ☐ leaves seat in classroom or in other situations where remaining seated is expected
- ☐ runs about or climbs excessively in situations in which it is inappropriate
- ☐ has difficulty playing or engaging in leisure activities quietly
- ☐ is "on the go" or acts as if "driven by a motor"
- ☐ talks excessively

Attention-Deficit/ Hyperactivity Disorder Verification Form

☐ blurts out answers before questions have been completed
☐ has difficulty waiting for their turn
☐ interrupts or intrudes on others

B. ☐ Several hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 12.
C. ☐ Several impairments from the symptoms are present in two or more settings
D. ☐ There is clear evidence of clinically significant impairment in social, academic or occupational functioning

7. Have you conducted a diagnostic interview with the student? This should include developmental, academic, family, psychosocial and medical history.

☐ Yes Date of interview _____
☐ No

8. Instruments used in determining diagnosis of ADHD:

☐ Conners Parent Rating Scale
☐ Conners Teacher Questionnaire
☐ Vanderbilt ADHD Diagnostic Parent Rating Scales
☐ Vanderbilt Teacher Assessment Scale
☐ Other_____
☐ None

9. How long have you been treating this student? Please indicate the approximate # of visits to date.

_____

10. Is the student currently prescribed medication(s)? ☐ Yes ☐ No

If yes, what? _____
If so, by whom? _____
Amount and frequency of administration: _____
Frequency of monitoring: _____
Response to Medication: _____
How will refills be obtained?_____

11. Is there any indication this student may have additional or comorbid diagnoses such as depression, anxiety, mood disorder, autism, substance abuse disorder, etc.? ☐ Yes ☐ No If yes, please explain:

_____
_____

Attention-Deficit/ Hyperactivity Disorder Verification Form

_____
_____

12. Have you recommended any type of therapy or other resources? ☐ Yes ☐ No

If yes, what specific referral was made? _____

13. Please state the student's **functional limitations** based on the ADHD diagnosis, specifically in a classroom or educational setting. _____
_____
_____
_____
_____
_____
_____
_____

14. Please list any specific recommendations regarding academic accommodations for this student and a rationale as to why these accommodations or services are warranted based upon the student's functional limitations. Indicate why the accommodations are necessary and if the student has previously utilized academic accommodations (if known). _____
_____
_____
_____
_____
_____
_____
_____

15. Additional Information:

a. What other specific symptoms currently manifesting might impact the student's academic performance? _____
_____
_____

b. Is there anything else we should know about the student's psychological disability?
_____
_____
_____
_____

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CERTIFYING PROFESSIONAL

Professional's Name _____Title _____
Name of Practice _____
Address _____
Email _____
Phone _____ Fax_____

Signature of Professional _____Date _____
License No. _____

Medical stamp is required. Please place medical stamp here:

**The certifying professional must have expertise in the differential diagnosis of the documented disability or condition and follow established practices in the field.