Verification of Disability Form: Autism Spectrum Disorder

Student Access at Davenport University strives to ensure that qualified students with autism spectrum disorder are accommodated to best assure the successful completion of academic requirements and to obtain the benefits of participation in the academic community. Students with disabilities must still satisfy essential academic program requirements, with or without accommodation.

Davenport University is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide effective services for qualified students with documented disabilities if such accommodations are needed to provide equal access to the University programs and services. Federal law defines a disability as “a physical or mental impairment that substantially limits one or more major life activities.” Major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. Attention deficit disorder in and of itself does not necessarily constitute an impairment. The degree of impairment must be significant enough to “substantially limit” one or more major life activity.

Students who wish to receive academic adjustments due to attention deficit disorder need to have this form filled out by a licensed professional qualified to make such a diagnosis. The professional completing this form must have firsthand knowledge of the student’s condition.

Release of Information

I, ________________________________, authorize the exchange and release of information regarding academic adjustments; auxiliary aids and/or accommodations related to my disability with relevant Davenport University academic and operations personnel. I understand that my disability related records including test scores, evaluations and diagnoses will be kept confidential and will be shared only on a need-to-know basis within the institution. I understand this consent will remain in effect as long as I am a current student at Davenport University or until revoked by me by giving written notice to the Student Access Coordinator at my location.

________________________________________  ________________
Student’s Signature                        Date

Student Information (This section to be completed by the student)

Last Name______________________________  First ___________________ MI ____
Student ID# ____________________________  Date of Birth ________________
Permanent Address ________________________  Phone ____________________
City______________________________  State ___  Zip Code ________________
Certifying Professional

Name ____________________________________________

Credentials ______________________________________

Address _______________________________________

City__________________________ State ______ Zip Code __________

Phone __________________________ Fax ______________________

License/Certification number and state of licenser ________________

Date of initial contact with student __________________________

Date of last contact with student __________________________

DSM IV Diagnosis

________________________________________________________________

________________________________________________________________

Date of Diagnosis __________________________

Basis on which diagnosis was made __________________________

________________________________________________________________

________________________________________________________________

If psychological tests were used please include all scores used to support the diagnosis __________

________________________________________________________________

________________________________________________________________

Current medications including dosage and side effects __________________________

________________________________________________________________

________________________________________________________________

Student’s current compliance with medication plan __________________________

________________________________________________________________

________________________________________________________________

Planned therapeutic interventions __________________________

________________________________________________________________

________________________________________________________________
Prognosis for therapeutic interventions (Include likelihood for improvement or further deterioration and within what approximate time frame.)

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Student’s current compliance with therapeutic interventions

__________________________________________________________________________________________

__________________________________________________________________________________________

Implications for academic and social functioning

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

**Implications for Educational Success**

Based on the results of your evaluation what accommodations would you recommend? Each recommended accommodation should be accompanied by an explanation of its relevance to the disability that is diagnosed. The final determination of any effective accommodation is left to the University. (Please circle and write a detailed explanation.)

*Please include a copy of diagnostic report with evidence that symptoms interfere with academic and/or social functioning.*

Extension of time to complete exams (Yes / No)

Why? ______________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Quiet room to take exams (Yes / No)

Why? ______________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________
Other (please specify)

Why?

I certify that the above information is accurate and complete.

__________________________________________________________
Signature of Licensed Professional

__________________________________________________________
Date

This form should be returned to the Student Access Coordinator at the location the student attends or

Davenport University
Center for Campus Life
Attn: Executive Director of Campus Life
6191 Kraft Avenue SE
Grand Rapids, MI 49512
Phone: (616) 554-5687
Fax: (616) 871-6730
Email: studentaffairs@davenport.edu