SJSU SAN JOSÉ STATE UNIVERSITY

ADHD/ADD Verification Form

Administration Bldg., Rm 110, One Washington Square, San Jose, CA 95192-0168 · v: (408) 924-6000; f: (408) 924-5999 · aec-info@sjsu.edu

To Evaluator: To qualify for support services from the Accessible Education Center at San José State University, an individual must have his/her disability verified by an appropriate licensed professional. Documentation necessary to substantiate the diagnosis must be comprehensive and be based on a comprehensive diagnostic/clinical evaluation.

Please Note: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Please note: Student medical records supplied to this office constitute "education records" under the Family Education and Privacy Act (FERPA) and as such, may be reviewed by the student upon written request.

For general questions pertaining to this form, or to obtain clarification about the information requested, please contact the AEC at (408) 924-6000 or at aec-info@sjsu.edu.

Verification requested for: _____

Student Name: (Last, First M.I.)

To be completed by licensed practitioner:

Name: _____

How often do you see this student? _____ Date of student's last visit: _____

Length of time this student has been under your care: _____

Diagnosis: ☐ ADHD ☐ ADD

Method(s) of Determining Diagnosis(es): *Check all that apply:*

☐ Comprehensive Diagnostic Evaluation ☐ Review of Medical Records ☐ (Nero) Psychological Assessment

☐ Consultation with Former Provider of Care ☐ Clinical Interview. ☐ Other: _____

Based on your diagnosis, how does the student's functional limitations* affect the student's ability to perform and function in an academic and test-taking environment (i.e. disorders of thinking, psychosis, reading comprehension, attention span, alertness, response speed, motor functions, writing, calculating, etc.)?

**Functional limitations are substantial limitations in an individual's ability to perform in a condition, manner, or duration of a required major life activity.*

_____

_____

_____

_____

_____

_____

Major Life Activity:

Does the impairment limit a major life activity? ☐ Yes ☐ No

If yes, what major life activity(ies) is/are affected? *Please check the level of limitation you believe this student experiences as a result of his/her's disability(ies). Check only those boxes that apply.*

1 = Unable to determine 2 = Mild 3 = Severe

1	2	3	Major Life Activity	1	2	3	Major Life Activity	1	2	3	Major Life Activity
			Impulsivity				Listing				Impatience
			Inattention				Organization				Distractibility
			Over-activity				Difficulty in following instructions				Failure to give attention to detail
			Excessive Talking				Interrupting Others				Processing
			Fidgeting				Focusing				Time management
			Performing Manual Tasks *(including household chores, bathing, brushing teeth)*								
			Other:								

1. For any major life activity where you indicated the limitation as "severe," what is significant about the student's diagnosis that severely impacts their functioning?

_____

_____

_____

_____

Prescribed Medication:

Medication(s):	#1	#2	#3
Dosage:			
Purpose of Medication:			
Side Effects *(check all that apply):*			
Decrease appetite	☐	☐	☐
Problems Sleeping	☐	☐	☐
Headaches	☐	☐	☐
Heart Palpitations	☐	☐	☐
Increased heart rate	☐	☐	☐
Neurologic Problems *(Hallucinations, psychosis, tics, seizures)*	☐	☐	☐
Sedation/Fatigue	☐	☐	☐
Dry mouth	☐	☐	☐
Cognitive/memory impairment	☐	☐	☐
Blurry Vision	☐	☐	☐
Other:			

Certifying Licensed Physician or Primary Health Care Provider qualified in the appropriate specialty area.

(Must be completed by a licensed practitioner)

Name: _____

(Last, First M.I.)

Medical Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

License Number: _____

Signature: _____ Date: _____

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