BATON ROUGE COMMUNITY COLLEGE

COUNSELING & ACCESSIBILITY SERVICES

ATTENTION DEFICIT/HYPERACTIVITY DISORDER (AD/HD) DOCUMENTATION REQUEST FORM

Student's Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Student Campus ID #_____

This student is requesting an auxiliary aid or service, academic adjustment, and/or other accommodations from the Office of Counseling & Accessibility Services due to AD/HD. In order to consider this request, as well as to ensure the provision of reasonable and appropriate auxiliary aids and services, college policy requires that a **Qualified Professional** provide current and comprehensive documentation of AD/HD. 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**. **IN ORDER TO BE CONSIDERED CURRENT, THE QUALIFIED PROFESSIONAL'S STATEMENT MUST BE WITHIN 3 YEARS PRIOR TO THE DATE OF THE MOST RECENT REQUEST FROM COUNSELING & ACCESSIBILITY SERVICES.**

******This form must contain ALL of the requested information below to apply for accommodations through the office of Counseling & Accessibility Services.******

1. Diagnosis (as diagnosed by the DSM-V): _____

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 AD/HD (must demonstrate that difficulties are not the result of sensory impairment, serious emotional disturbance, cultural differences, or insufficient instruction): _____

_____

_____

_____

_____

_____

_____

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

6. List **current medication(s)**, along with any **current side effects** that may have impact on academic performance: _____

7. Please indicate the **RECOMMENDATIONS** you have regarding necessary and appropriate auxiliary aids or services, or other accommodations to equalize the student's educational opportunities at BRCC 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: _____

PLEASE NOTE: Counseling & Accessibility Services **strongly recommends** maintaining copies of any submitted documentation for personal records.

Counseling & Accessibility Services
Phone: 225/216-8643 | Fax: 225/216-8642 | accessibilityservices@mybrcc.edu