



**Documentation for Medical and Psychological Conditions and Suggested Accommodations (DRC102)**

**Notice: The Disability Resource Center, EMU, promotes compliance with Section 504 of the Rehabilitation Act and the Americans with Disabilities. To accomplish that it is necessary that we rely on the student’s personal interview, shared history, assessments, documentation, and clinical recommendations by medical professionals. The appropriate level of accommodation should provide the student with access to an educational opportunity. However, accommodations are not intended to be excessive or redundant. We caution not to overdo or go beyond “appropriate documentations” to avoid depriving the student of educational and social opportunities associated with the University learning community.**

**1. To be completed by the student (your request constitutes an authorization for release of medical information from your providers to EMU/DRC):**

Student’s Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Student DOB: \_\_\_\_\_

**2. To be completed by treating physician or other licensed professional. Please print legibly.**

\_Diagnosis: \_\_\_\_\_

\_Current GAF: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_ Date of last visit for this condition: \_\_\_\_\_

\_Procedures/assessments used to diagnose this student’s condition (Please Attach Copies of the assessment results used in making/confirming diagnosis): \_\_\_\_\_

\_Severity of the condition: \_\_\_Mild \_\_\_Moderate \_\_\_Severe. Comments: \_\_\_\_\_

\_Is student adhering to medical treatment plan for this condition: \_\_\_Yes \_\_\_No \_\_\_Inconsistently \_\_\_Unknown

\_Does student take prescription medication for this condition? : \_\_\_Yes \_\_\_No \_\_\_Inconsistently

\_Unknown If yes, list the medications and special concerns: \_\_\_\_\_

\_Medical equipment (other treatment, comfort, or optional considerations) prescribed for this student’s home or school environment: \_\_\_\_\_

\_Has this student been treated in an emergency room for this condition within the last year? (Circle one): Yes No

\_Has this student received in-patient treatment for this condition within the last year? (Circle one): Yes No

\_Explain how this condition significantly limits a major life activity. Major life activities “are those basic activities that the average person in the general population can perform with little or no trouble.” \_\_\_\_\_

\_With what frequency does this student experience the above limitation(s)? \_\_\_Rarely \_\_\_Occasionally \_\_\_Frequently

\_Will the above limitation(s) interfere with this student’s ability to participate in student life (e.g., academics, recreation, etc.)? \_\_\_\_\_

\_Could excessive accommodation or optional conditions interfere with the student academic and personal development?

\_\_\_ Yes \_\_\_ No

\_Suggested health-care management plan of this condition: \_\_\_\_\_

\_Suggested accommodation (clearly linked to functional limitations): \_\_\_\_\_

Physician’s Name: \_\_\_\_\_ Physician Signature: \_\_\_\_\_

License/Cert. #: \_\_\_\_\_ Specialty: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_