Documentation Form for Students with Functional Impairment due to Medical Conditions

The student named below has applied for services from the Disability Services (DS) at Westmont College. In order for DS to establish whether this student has a disability and to determine eligibility for services we will need your assessment and diagnosis of this student. A disability is defined as a physical or mental impairment that limits one or more major life activities such as those delineated below. You can fax or mail the form to us at the address listed on this form. If you prefer, you can answer these questions in a signed and dated letter on your professional letterhead.

For more information on Disability Services visit our website at Westmont.edu.

Today’s date: _____________________________________________________

Student’s Name: __________________________________________________

Date of Birth: ____________________________________________________

Month   Date   Year

1. What is the diagnosis/impairment?

   __________________________________________________________________

   __________________________________________________________________

   __________________________________________________________________

   __________________________________________________________________

2. What is the date of diagnosis/impairment?

   ________________________________________________________________
3. Major Life Activities Assessment: Please use a checkmark to indicate the disability’s impact, if any, on the activities listed below, and describe the impact if appropriate.

<table>
<thead>
<tr>
<th>Life Activity</th>
<th>No impact</th>
<th>Moderate impact</th>
<th>Severe impact</th>
<th>Don't know</th>
<th>Please describe if moderate or severe impact</th>
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<tbody>
<tr>
<td>Walking (e.g., how far/long can student walk, use of mobility devices such as wheelchair, etc.)</td>
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<td>Standing (e.g., duration)</td>
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<td>Sitting (e.g., duration)</td>
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<td>Performing manual tasks (e.g., reaching, manipulating materials &amp; lab equipment, etc.)</td>
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<td>Writing/Keyboarding (e.g., unable to keyboard more than 10 min., unable to handset, etc.)</td>
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<tr>
<td>Speech Impairment</td>
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<td>Breathing</td>
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<td>Sleeping (or attach most recent sleep study)</td>
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<td>Caring for oneself (e.g., personal care, laundry, household tasks, etc.)</td>
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<td>Hearing (or attach most recent audiogram)</td>
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<td>Vision (or attach most recent eye exam)</td>
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<td>Other</td>
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</tbody>
</table>
4. Please describe the effect of the medical condition, including side effects and/or pain symptoms, on academic performance (e.g., concentration, reading, thinking, learning, etc.) and attendance.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

5. Please list medications and possible side effects on academic performance and attendance.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

6. If student is undergoing treatment, please describe how treatment (e.g., frequency of treatments, side effects of treatments, etc.) may affect student’s performance and attendance.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

7. Will the functional limitations last for the duration of the student’s matriculation at Westmont College?
   Yes ________ No ________

8. If functional limitations fluctuate, how frequently did the student experience flare-ups within the past 12 months or since onset of diagnosis?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
9. When and/or how often should the student be evaluated? Or, if limitations are not permanent, when will the injury be resolved?

________________________________________________________________________________________
________________________________________________________________________________________
_____________________________________________________________________________________

10. Please attach any relevant supporting documentation

________________________________________________________________________________________
________________________________________________________________________________________
_____________________________________________________________________________________

Certifying Medical Professional

_________________________________________________               _______________________
Signature of Medical Professional      Date

_________________________________________________            ________________________
Medical Professional’s Name (printed)                  License Number

_________________________________________________  ________________________
Address         Telephone Number

_________________________________________________  ________________________
City, State, ZIP       Fax