



License Number:

---

1) Is the student currently under your care, if so for how long?

Circle Yes/No Length of Care: \_\_\_\_\_

2) What is the current diagnosis(es)? Please use ICD 10 codes:

---

---

3) When did you last examine the student?

Major Life Activity Assessment:

Please Circle the level of limitation created by the students diagnosis(es) and if substantial, please describe specifically how this can impact the student in the educational setting e.g. taking notes, studying, completing tests on time, reading, navigating the campus, attending class or any other typical components of college life.

**Speaking**

Circle one: No Limitation                      Mild                      Moderate                      Substantial

**If Substantial please provide specific information on the impact of the functional limitations to the students academic pursuits:**

---

---

---

**Hearing**

Circle one: No Limitation                      Mild                      Moderate                      Substantial

Describe Academic Impact of Substantial Limitations:

---

---

---

**Seeing**

Circle one: No Limitation                      Mild                      Moderate                      Substantial

FOR PHYSICAL CONDITIONS ONLY

Describe Academic Impact of Substantial Limitations:

---

---

---

**Walking**

Circle one: No Limitation                  Mild                  Moderate                  Substantial

Describe Academic Impact of Substantial Limitations:

---

---

---

**Breathing**

Circle one: No Limitation                  Mild                  Moderate                  Substantial

Describe Academic Impact of Substantial Limitations:

---

---

---

**Standing**

Circle one: No Limitation                  Mild                  Moderate                  Substantial

Describe Academic Impact of Substantial Limitations:

---

---

---

**Lifting**

Circle one: No Limitation                  Mild                  Moderate                  Substantial

Describe Academic Impact of Substantial Limitations:

---

---

---

**Sitting**

Circle one: No Limitation                      Mild                      Moderate                      Substantial

Describe Academic Impact of Substantial Limitations:

---

---

---

**Performing Manual Tasks (dexterity)**

Circle one: No Limitation                      Mild                      Moderate                      Substantial

Describe Academic Impact of Substantial Limitations:

---

---

---

**Writing**

Circle one: No Limitation                      Mild                      Moderate                      Substantial

Describe Academic Impact of Substantial Limitations:

---

---

---

**Sleeping**

Circle one: No Limitation                      Mild                      Moderate                      Substantial

Describe Academic Impact of Substantial Limitations:

---

---

---

**Concentration**

Circle one: No Limitation                      Mild                      Moderate                      Substantial

Describe Academic Impact of Substantial Limitations:

---

---

---

**Memory**

Circle one: No Limitation                  Mild                  Moderate                  Substantial

Describe Academic Impact of Substantial Limitations:

---

---

---

**Reading**

Circle one: No Limitation                  Mild                  Moderate                  Substantial

Describe Academic Impact of Substantial Limitations:

---

---

---

**Caring for Self**

Circle one: No Limitation                  Mild                  Moderate                  Substantial

Describe Academic Impact of Substantial Limitations:

---

---

---

**Other:**

Circle one: No Limitation                  Mild                  Moderate                  Substantial

Describe Academic Impact of Substantial Limitations:

---

---

---

4) Are the limitations described above permanent, if not how long will they be present?

---

---

---

**5) List medications which the student is taking and please describe any problematic side effects:**

---

---

---

**6) List any regular treatments the student may be undergoing (chemotherapy, dialysis) and describe how this may create difficulties for the student.**

---

---

---

\_\_\_\_\_  
**Signature Of Health Care Professional**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**Phone/Fax**