Accessibility Services
WOFFORD COLLEGE

Health Condition Documentation Form

This Health Condition Documentation Form will be used to support a student's request for disability accommodations at Wofford College. It should:

a. **Reflect the most currently available information**
b. **Be completed by a qualified professional**
c. **Be completed as clearly and thoughtfully as possible.** Incomplete responses and illegible handwriting may require additional follow up.
d. **Be supplemented with reports or additional testing, if applicable.** Please do not provide case notes or test results without a narrative that explains the content.

We must first determine if this is an Otherwise Qualified Individual with a Disability. Federal law defines a person with a disability as someone who has a physical or mental impairment that ***substantially limits*** *one or more major life activities. The presence of a diagnosis (label) does not necessarily equate with a disability (substantial limitation).*

Student Name: ____ **Birthdate:** __________
Last First M.I.

Date of initial assessment for diagnosis: ____________________________________

Date of most recent assessment: ____

List all diagnoses for which student is requesting accommodation (including severity levels):

____

____

____

____

Check all applicable impacts or symptoms of this student's diagnosis:

____ Low/High Blood Glucose Levels
____ Anaphylaxis
____ Hives/Rash
____ Headaches
____ Light Sensitivity
____ Aura/Visual Field Disturbance
____ Fainting
____ Dizziness
____ Brain Fog
____ Urgent/Frequent Restroom Use
____Seizures (Type___________)
____Muscle Weakness
____Nausea
____Vomiting
____Concentration/Attentional Difficulties
____Sleep Disturbance (Type: ___________)
____Pain (List type & location of pain):
____

List any other impacts or symptoms that are not listed above (Impacts may include social, housing, attendance, etc.):

____

____

Discuss any *side effects related to treatment or mediations* that may be relevant to identifying accommodations:

____

____

Please *provide any additional information you feel is pertinent* or may be of use in the accommodation process.

____

____

Provider Name (Print): ____

Provider Signature: ____

License or Certification #:____State: _____________________

Address: ____

Phone:________________________Fax: _____________________________Date: ___________________

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