RELEASE OF INFORMATION

FOR VERIFICATION OF ATTENTION DEFICIT/HYPERACTIVITY DISORDER

The student completes the following:

I, ________________________________, hereby authorize the release of the following information as well as any pertinent documentation to the Student Accessibility Services at Florida Atlantic University for the purpose of determining my eligibility for academic accommodations.

Student’s Signature ________________________________ Phone: __________________

Student’s Z# ________________________________ Date of Birth: __________________

Please return the completed information to the appropriate campus:

☐ Florida Atlantic University
   Student Accessibility Services
   777 Glades Road, SU 133
   Boca Raton, FL 33431
   tel: 561.297.3880  fax: 561.297.2184

☐ Florida Atlantic University
   Student Accessibility Services
   3200 College Avenue, LA 131
   Davie, FL 33314
   tel: 954.236.1222  fax: 954.236.1123

☐ Florida Atlantic University
   Student Accessibility Services
   5353 Parkside Drive, SR 111F
   Jupiter, FL 33458
   tel: 561.799.8585  fax: 561.799.8819

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INFORMATION FOR DIAGNOSTICIAN

To ensure the receipt of reasonable and appropriate accommodations, students needing services must provide current documentation of their disability. FAU Student Accessibility Services is required to maintain confidential records of this student’s conditions for the purpose of accommodation according to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendment Act of 2008.

This documentation should provide information regarding the onset, longevity, and severity of symptoms, as well as specifics describing how it interferes with educational achievement. Assessment of current functioning is necessary.

Thank you for your assistance.
ADHD VERIFICATION FORM

Florida Atlantic University provides academic accommodations and services to students with documented disabilities in keeping with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments Act of 2008 (ADAAA). Students seeking accommodations are responsible to provide documentation of a disability resulting in the substantial limitation of one or more major life activities. This form, if completed fully, could provide such documentation. If this form is incomplete, illegible, or provides inadequate information, the review process for the student may be delayed significantly, preventing a potentially qualified student from receiving accommodations. **Licensed psychologists or psychiatrists are the only clinicians qualified to completed this form.**

Student’s Name ____________________________________________

**DSM 5 DIAGNOSIS**

☐ 314.00 (F90.0) ADHD, predominantly inattentive presentation
☐ 314.01 (F90.1) ADHD, predominantly hyperactive / impulsive presentation
☐ 314.01 (F90.2) ADHD, combined presentation

**Specifiers:**

☐ In partial remission ☐ Moderate
☐ Mild ☐ Severe

Date of diagnosis ____________________ Date of first contact _______________________
Date of last contact ______________________

Appointment dates within the last six months ________________________________________
____________________________________________________________________________
____________________________________________________________________________

**Diagnostic tools (check all that apply):**

☐ Clinical interview(s) ☐ Behavioral observations
☐ Rating scales ☐ Developmental or medical history
☐ Neuropsychological or psychoeducational evaluation - Please provide complete copies of the report(s), including standard scores.
☐ Standardized tests of attention, e.g. TOVA, CPT – Please submit copies of results along with a narrative explaining the results.

**Additional relevant information**

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
CURRENT SYMPTOMS

314.00 (F90.0) ADHD, predominantly inattentive presentation
☐ Fails to give close attention to details or makes careless mistakes (e.g., overlooks or misses details, work is inaccurate).
☐ Often has difficulty sustaining attention in tasks (e.g., difficulty remaining focused during lectures, conversations, or lengthy reading).
☐ Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
☐ Often does not follow through on instructions and fails to finish schoolwork or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).
☐ Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).
☐ Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; preparing reports, completing forms, reviewing lengthy papers).
☐ Often loses things necessary for tasks or activities (e.g., school materials, books, tools, wallets, keys, paperwork, eyeglasses, mobile phones).
☐ Is often easily distracted by extraneous stimuli, including unrelated thoughts.
☐ Is often forgetful in daily activities (e.g., doing chores, running errands, returning calls, paying bills, keeping appointments).

314.01 (F90.1) ADHD, predominantly hyperactive / impulsive presentation
☐ Often fidgets with or taps hands or feet or squirms in seat.
☐ Often leaves seat in situations when remaining seated is expected (e.g., leaves his/her place in the classroom or workplace).
☐ Often feels restless.
☐ Often unable to engage in leisure activities quietly.
☐ Is often “on the go,” acting as if “driven by a motor” (e.g., unable or uncomfortable being still for extended time).
☐ Often talks excessively.
☐ Often blurts out an answer before a question has been completed (e.g., completes people’s sentences, cannot wait for turn in conversation).
☐ Often has difficulty waiting his/her turn (e.g., while waiting in line).
☐ Often interrupts or intrudes on others (e.g., butts into conversations or activities; may start using other people’s things without asking or receiving permission; may intrude into or take over what others are doing).

314.01 (F90.2) ADHD, combined presentation – Check all of the above that apply.
TREATMENT

☐ Actively engaged in counseling / therapy
  Start date______________________________________________________________
  Type of counseling / therapy______________________________________________
  Frequency_____________________________________________________________
  Expected duration_______________________________________________________

☐ Medication
  Medication_________________________________ Dosage_____________________
  Medication_________________________________ Dosage_____________________
  Medication_________________________________ Dosage_____________________
  Medication_________________________________ Dosage_____________________
  Side effects_____________________________________________________________
  ________________________________________________________________

Other treatment / relevant information______________________________________
  ________________________________________________________________

FUNCTIONAL LIMITATIONS
Explain how the student’s current symptoms impact academic endeavors.
  ________________________________________________________________
  ________________________________________________________________
  ________________________________________________________________
  ________________________________________________________________
  ________________________________________________________________
  ________________________________________________________________

ADDITIONAL INFORMATION
  ________________________________________________________________
  ________________________________________________________________
  ________________________________________________________________
  ________________________________________________________________

CLINICAN’S NAME (Printed) ______________________________________________
CLINICIAN’S SIGNATURE________________________________________________
CREDENTIALS_________________________________________________________
SPECIALTY, IF ANY_____________________________________________________
LICENSE/CERT. # __________________________________ STATE_______________
DATE______________________________________________________________

*Please attach your business card.