Department of Counseling and Disability Services
7373 Admiral Peary Highway
Cresson PA 16630-1999
www.mtaloy.edu
(814) 886-6336
Fax: (814) 886-6575

Verification of Disability Form for General Medical Conditions

(Please print)

Purpose: The student named below has indicated that s/he has a medical condition that rises to the level of disability and will require reasonable accommodations to participate in a program or activity (including housing and meal plans) at Mount Aloysius College. The information you provide will be used to determine the nature and severity of the student's condition and the appropriateness of requested accommodations or services.

Please take the time to complete this form in its entirety. **Contact the Department of Disability Services at (814) 886-6515 with any questions.** All information provided to us is kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA). A signed consent for release of information should be completed by the student prior to the release of this form. Thank you for your assistance. **Return completed form and documentation to: Department of Counseling and Disability Services, Mount Aloysius College, 7373 Admiral Peary Highway, Cresson, PA 16630**

Student Name: _____

Diagnosis: _____

Date of Diagnosis: _____

Date of last visit for this condition: _____

Procedures/assessments used to diagnose this student's condition (Please attach a copy of test results; eg: allergy testing, pulmonary function testing, etc.):

_____

_____

_____

Severity of the condition (circle one): Mild Moderate Severe In Remission

Has the student been treated in an emergency room or hospital for this condition with the last year? YES NO

Total number of hospitalizations related to this condition: _____

Date of last hospitalization: _____

What environmental factors exacerbate this condition? _____

_____

_____

Does the student take prescription medication for this condition? YES NO

If yes, please specify medications, dosage and frequency:

Medication	Dosage	Frequency

What are the functional limitations caused by this condition and/or its treatment? _____

_____

_____

Recommended accommodation (must be clearly linked to functional limitations):

_____

_____

_____

Anticipated duration of need for accommodation: _____

_____

Name of Medical Professional: _____

License #: _____

Please indicate State: _____

Address: _____

Telephone: _____

Signature: _____ Date_____