RUTGERS
Office of Disability Services

**Office of Disability Services**
Lucy Stone Hall, Suite A145
Rutgers, the State University of New Jersey
54 Joyce Kilmer Avenue
Piscataway, NJ 08854

ods.rutgers.edu
ods@echo.rutgers,edu

p: 848.445.6800
f: 732.445.3388

# Medical Condition Documentation Form

| | |
|---|---|
| Student's First Name: | |
| Student's Last Name: | |
| Date of Birth: | |
| Student's Street Address: | |
| City: | |
| State: | |
| Zip Code: | |

| | |
|---|---|
| Diagnosis and description of the student's medical condition | |

When was the condition first diagnosed?

Date of initial contact with the student:

Date of last contact with the student:

Frequency of appointments

- ☐ Once a week
- ☐ Twice a week
- ☐ Once a month
- ☐ Once every six months
- ☐ Once a year
- ☐ On an as-needed basis

What is the severity of the condition?

☐ Mild
☐ Moderate
☐ Severe

Explain the severity selected above:

What is the expected duration of the condition?

☐ Short-term (less than 6 months)
☐ Episodic
☐ Long-term (6 months-1 year)
☐ Chronic (longer than 1 year with frequent recurrence

Is the student able to ambulate?

☐ Yes
☐ No

Can the student negotiate stairs, or is an elevator required? Please explain.

Please list the student's current symptoms. Then, indicate what reasonable academic accommodations would be related to the symptom indicated. (More detailed information regarding reasonable academic accommodations can be found at: reasonable accommodations).

**Example:** Symptom: "Due to the student's Crohn's Disorder, the student has frequent stomach pain and is required to use the restroom numerous times throughout the day. Often this is an emergency type of frequency and may affect attendance."

**Recommended Reasonable Accommodation:** "Student will require frequent breaks, consideration of attendance policies, and possibly breaks during quizzes or exams as necessary without penalty."

**Symptom 1**

**Recommended Reasonable Accommodation**

**Symptom 2**

**Recommended Reasonable Accommodation**

**Symptom 3**

**Recommended Reasonable Accommodation**

**Symptom 4**

**Recommended Reasonable Accommodation**

**Symptom 5**

**Recommended Reasonable Accommodation**

Is the student currently taking any medication? ☐ Yes
☐ No

If yes, please provide information on each medication below:

**Medication 1, Dosage, & frequency** (e.g., Celebrex, 200 mg, 1x daily)

Date prescribed:

Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.)

**Medication 2, Dosage, & frequency** (e.g., Celebrex, 200 mg, 1x daily)

Date prescribed:

Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.)

**Medication 3, Dosage, & frequency** (e.g., Celebrex, 200 mg, 1x daily)

Date prescribed:

Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.)

## PROVIDER INFORMATION

Name of physician/provider completing form:

License number:

Date:

Profession:

Provider's address

Provider's phone number:

Provider's e-mail:

Provider's fax number:

*Note: Please upload any supporting documentation that you feel can assist our office in the determination of reasonable accommodations.