Chronic Health Conditions Documentation Form

Student Name: ________________________ DOB: __/__/____ has requested support services from Accessible Educational Services (AES) at Indiana University Bloomington (IUB) regarding a chronic health condition. Documentation provides vital information about the functional limitation of the student’s disability and its impact in a post-secondary academic environment.

There are a variety of health conditions that may affect a student's academic functioning while in college. Examples of chronic health disorders include, but are not limited to: Crohn’s disease, cystic fibrosis, Ehlers-Danlos Syndrome, diabetes, Lyme disease, or rheumatoid arthritis.

Please complete all sections of this form and return it as soon as possible so that we may verify the student’s eligibility for services. Providers may also use their own documentation format if all the information requested below is included; if this information is not provided, services may be delayed as AES obtains clarification. Please call 812-855-7578 if you have questions. The completed form may be faxed to 812-855-7650 or it may be mailed to the address at the bottom of this page. AES welcomes any additional documentation you would like to include.

**Diagnoses:**
Primary: __________________________________________
Secondary: __________________________________________
Date of Diagnosis: __/__/____ Initial visit: __/__/____ Last appointment: __/__/____

**Basis on which Diagnosis was made:**
__________________________________________________________________________
__________________________________________________________________________

**Clinical Manifestations or Current Symptoms:**
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

**Characteristics of Chronic Health Condition:** *(Check all Appropriate Terms)*
☐ Stable  ☐ Slow Progressing  ☐ Rapid Progressing  ☐ Improving  ☐ Mild  ☐ Moderate  ☐ Severe

**Current medical treatment that may affect the student in the higher education environment.**
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

**Do the student’s symptoms fluctuate or worsen** ☐ Yes  ☐ No  If yes, please explain:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

**How long do you anticipate the condition impacting academic achievement? (Check one)**
☐ < 6 months  ☐ < 1 year  ☐ > 1 year
Prescribed medication and the side effects that impact academic functioning:

____________________________________________________________________________________________
____________________________________________________________________________________________

Implications for Educational Success/Major Life Activities (REQUIRED):
Please check which of the major life activities listed below are affected because of the diagnosis.

Substantial limitation is defined as a “significant restriction in the condition, manner, or duration in which a major life activity is performed compared to most people.”

☐ Concentration*
☐ Memory*
☐ Sleeping
☐ Other ______________

☐ Fine Motor Skills
☐ Stress Management
☐ Walking
☐ Other ______________

☐ Communication
☐ Eating
☐ Lifting
☐ Other ______________

*Note: Appropriate psychometric data should be included for these areas of limitation.

Additional comments and recommended auxiliary support, strategies, or service that may be beneficial to the student in the higher education environment.

_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

Certifying Professional

Name (print): _____________________________ Date: ___ / ___ / ___

Profession: _____________________________ License number: _____________________________

Office Address: ___________________________

Phone: __________________ Fax: ______________ Email Address: _____________________________

Certifying Professional Signature: ___________________________