



DISABILITY SERVICES
University of South Carolina Upstate
800 University Way, CLC 107
Spartanburg, SC 29303
864-503-5199

Attention Deficit Hyperactivity Disorder (ADHD) Verification Form

The student named below has applied for academic accommodations through Disability Services at USC Upstate. In order to determine eligibility, we require current and comprehensive documentation of the student's disability.

Under the ADA Amendments Act of 2008 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities. The documentation must also support the request for accommodations and academic adjustments.

After completing this form, please return it to the student or, with the student's permission, you may return it to our office. The information you provide will be held confidential and will not become part of the student's educational records. In addition to the requested information, please attach any reports which provide additional related information. Please contact us at 864/503-5199 or email Disability Services at DSINFO@uscupstate.edu if you have any questions or concerns. Thank you for your assistance.

Consent For External Release of Information

I, _____, authorize _____ to release to Disability Services at the University of South Carolina Upstate any and all information that is relevant to my disability, the functional limitations imposed by my disability and any recommendations of possible accommodations including, but not limited to, the information in the attached form.

Student Signature: _____ Date: _____

1. Student's Name (Last, First, Middle): _____

2. What is your DSM-V Diagnosis for this student?

_____ 314.01 (Attention-Deficit/Hyperactivity Disorder, Combined Type)

_____ 314.00 (Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type)

_____ 314.01 (Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type)

_____ 314.9 (Attention-Deficit/Hyperactivity Disorder, Not Otherwise Specified)

3. What rating scales and test instruments were administered to assist in assessing/diagnosing for ADHD?
(Please attach test scores/results)

4. Summarize the information from the clinical interview used to make the diagnosis and rule out differential diagnoses and other conditions:

5. Date of Diagnosis: ____/____/____ Date of Initial Diagnosis: ____/____/____

Approximate date of onset: ____/____/____

6. Date student was last seen: ____/____/____

7. What is the severity of the disorder? ____ Mild ____ Moderate ____ Severe

Please describe the severity checked above:

8. Please check which of the major life activities listed below are significantly affected as a result of his/her ADHD. Please indicate the level of limitation.

| Life Activity | No Impact | Moderate Impact | Severe Impact | Don't Know |
|----------------------------------|-----------|-----------------|---------------|------------|
| Learning | | | | |
| Reading | | | | |
| Concentrating | | | | |
| Thinking | | | | |
| Communicating | | | | |
| Organizing | | | | |
| Activation/ Initiating to Work | | | | |
| Sustaining Focus | | | | |
| Memory | | | | |
| Stress Management | | | | |
| Timely Submission of Assignments | | | | |
| Understanding Directions | | | | |
| Managing Internal Distractions | | | | |
| Managing External Distractions | | | | |

9. State the student's functional limitations (challenges for academics arising from the condition) based on the ADHD diagnosis, specifically in a post-secondary environment:

10. Is the student currently taking medication for ADHD? If so, please describe the medications, dosage, date prescribed, effect on academic functioning, and possible adverse side effects.

11. Please state specific recommendations regarding academic accommodations for this student and provide your rationale for these recommendations.

12. Is there anything else you think we should know about this student?

13. Describe any referrals for additional testing/evaluation for this student:

Certifying Professional:

Signature of Professional

Date

Professional's Name (Printed) and Title

Name of Practice

Professional Credentials

License or Certification No.

Address

Telephone No.

City, State, Zip

Fax

Disability Services
Division of Student Affairs
University of South Carolina Upstate
800 University Way, CLC 107, Spartanburg, SC 29303
Fax to 864-347-3328 or email Disability Services at DSINFO@uscupstate.edu.