PART I
TO BE COMPLETED BY EVALUATOR

DISABILITY SERVICES – LOUISIANA STATE UNIVERSITY

ATTENTION DEFICIT/HYPERACTIVITY DISORDER (ADHD) DOCUMENTATION REQUEST FORM

Student's Name: ____

Phone Number: ____________________________ Date of Birth: __________________________

When did/will you start attending LSU? Semester__________________ Year: __________________

LSU I.D. Number: ______________________ LSU Email: ________________________________

This student is requesting an auxiliary aid or service, academic adjustment, and/or other accommodations from Disability Services. In order to consider this request, as well as to ensure the provision of reasonable and appropriate auxiliary aids and services, university policy requires that a **qualified professional** provide current and comprehensive documentation of ADHD. A qualified professional includes a licensed psychiatrist, psychologist, medical doctor, or other qualified mental health professional **who is not a family member of the student**.

****** This form must contain ALL of the requested information below in order to apply for accommodations through Disability Services. ******

1. Diagnosis (as diagnosed by the DSM-5): ____

2. If you have a formal evaluation, please attach it.

3. Date of Diagnosis: __________________ Date of Last Contact with Student: __________________

4. Provide a summary of the student's educational, medical, and family history that may relate to ADHD (must demonstrate that difficulties are not the result of other conditions, cultural differences, or insufficient instruction):

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5. Describe the student's functional limitations (i.e., current and/or anticipated problems associated with the condition) in an educational setting.

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6. List **current medication**, along with any **current side effects** that may impact academic performance:

7. Please indicate below the **RECOMMENDATIONS** you have regarding necessary and appropriate auxiliary aids or services or other accommodations to equalize the student's educational opportunities at LSU as justified based on the functional limitations indicated above.

Qualified Professional's Signature: ____________________

Printed Name & Title: ____________________

License or Certification Number: ____________________

Daytime Telephone Number: ____________________

Address: ____________________

Date: ____________________

Disability Services
Louisiana State University
124 Johnston Hall
Baton Rouge, LA 70803
Phone: 225-578-5919
Fax: 225-578-4560

PART II
TO BE COMPLETED BY STUDENT

DISABILITY SERVICES – LOUISIANA STATE UNIVERSITY

REQUEST FOR ACCOMMODATIONS

Student's Name: ____

Phone Number: ____________________ Date of Birth: ____________________

When did/will you start attending LSU? Semester______________ Year: ______________

LSU I.D. Number: __________________ LSU Email: ________________________

LSU enrollment for which you are requesting accommodations (check below):

LSU A&M (Main Campus) LSU Law Center Vet School LSU Online

Independent and Distance Learning (Enrollment #) __________

I am requesting accommodations because I have been diagnosed with one or more of the following disabilities which functionally impairs my ability to perform in an academic environment (check all that apply):

Attention Deficit Hyperactivity Disorder (ADHD)

Learning Disability

Deaf & Hard of Hearing

Psychological Disability (specify):________________________________

Physical or Medical Disability (specify): ____________________________

Temporary Disability (specify):__________________________________

In the space below, please list and explain the reason for each of the accommodations you are requesting.

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Signature of Student: __________________________ Date: ____________________

***Please note: Disability Services strongly recommends maintaining copies of any submitted documentation for personal records.**