UNIVERSITY OF DALLAS

Student Disability Services ♦ ***Academic Success Office*** ♦ Haggar 253
1845 East Northgate Drive ♦ Irving, Texas 75062 ♦ www.udallas.edu/academic-success
Phone (972) 721-5056 ♦ Facsimile (972) 265-5712 ♦ Email ada@udallas.edu

Student Disability Services
Verification Form for Students with Physical Disabilities or Medical Conditions

This form is intended to assist in meeting our documentation requirements for dining accommodation requests for students with disabilities. To standardize our gathering of information, we ask that you complete the following questions, even if the material has already been included in your evaluation. All information will be kept confidential. Please feel free to contact the ADA/Section 504 Coordinator at (972) 721-5056 with questions.

The information below and the release of information on the second page are to be completed and signed by the student.

_____

Student Name UD ID

_____

Student Signature Date

Email Address: _____

Phone Number: _____

If the information above is left blank or is incomplete it may delay or prevent SDS from contacting the student to verify receipt of the documentation and provide next steps for completing the registration process.

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION TO STUDENT DISABILITY SERVICES

Pursuant to Federal and State law concerning my right to confidentiality and privileged communication, I, _____, hereby authorize:

_____
Person or Organization

_____
Address

_____
City, State, Zip Code

_____ _____
Phone Number Fax Number

To release the following information:

_____ Information Requested on this Verification Form

_____ Diagnosis

_____ Psych-Educational/Neuropsychological Evaluations

_____ Psychological Evaluation

_____ History of previously used accommodations

_____ Other: _____

Documentation needed to request academic, dietary, and/or housing accommodations at post-secondary institution.

The information is to be provided to:

Student Disability Services, Braniff
132 University of Dallas
1845 East Northgate Drive
Irving, Texas 75062
Phone: (972) 721-5056
Fax: (972) 265-5712
Email: ada@udallas.edu

Purpose of disclosure:

I understand this authorization for confidential information applies only to the individual named above and only for a period of 180 days and does not permit the release of information concerning me to any other individual. In addition, I understand I may revoke this consent to release information at any time, but recognize that any release made between the time I authorized it and then revoked it shall not constitute a breach of my right to confidentiality.

A photocopy or fax of this authorization shall be considered as effective and valid as the original.

Student Signature: _____ Date: _____

UD Student ID: _____ Date of Birth: _____

The information below is to be completed and signed by the Provider.

1. **Diagnosis**: Please list all relevant diagnoses.

_____

_____

a. Approximate onset of symptoms

- ○ Child-approximate age: _____
- ○ Adolescent-approximate age: _____
- ○ Adult-approximate age: _____
- ○ Unknown

b. Date of current diagnoses: _____ /_____ /_____

c. Date of your last clinical contact with student: _____ /_____ /_____

d. Number of consultations with you in the past 3 years: _____

2. **Evaluation**

a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.

- ○ Medical evaluation (x-ray, lab work, EKG, etc.)
- ○ Structured or unstructured interviews with student.
- ○ Interviews with other persons (i.e. parent, teacher, therapist).
- ○ Behavioral observations.
- ○ Neuropsychological testing. Attach documentation.
- ○ Psychoeducational testing. Attach documentation.
- ○ Other (Please specify). _____

b. Evaluation Results:

_____

_____

c. Present symptoms that meet criteria for diagnosis being noted:

_____

_____

d. Current treatment being received by student:

- ○ Medication management:
  Current medications: _____
- ○ Physical / Occupational therapy:
  Frequency: _____

○ Other (please describe):

_____

e. This condition is …

○ Permanent

○ Temporary. The anticipated duration of the condition is _____

f. Severity of symptoms

○ Mild

○ Moderate

○ Severe

g. Prognosis of disorder:

○ Good

○ Fair

○ Poor

Please explain: _____

_____

3. **Functional Limitations**: *Should be determined WITHOUT consideration of mitigating measures (i.e. medication, etc.). If condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms.*

a. Using as much space as needed, please describe the type, severity, and frequency of symptoms currently experienced by the student, and how the disability interferes with eating or dining in University facilities. Please attach a separate sheet if more space is required.

_____

_____

_____

_____

_____

_____

b. Medical/therapeutic equipment needed: _____

c. Special considerations, e.g. medication side effects:

_____

_____

_____

4. **Accommodations**

a. Please mark whether student has utilized accommodations in the past.

○ Yes- Please describe:

_____

○ No

○ Don't Know

b. Please indicate which modifications you believe are necessary to accommodate the student's medically necessary dietary needs:

○ Access to the Gluten Friendly section (including baked goods, soups, sandwiches, etc.)

○ Access to Dairy Free menu options

○ Access to Vegetarian menu options

○ Access to Vegan menu options

○ Specialized diets for Gastrointestinal Diseases (e.g., Crohn's, Colitis, IBS)

○ Specialized diets for Diabetes

○ Menu planning consultation with Dining Services Staff

○ Consultation with staff Nutritionist

○ Other (please describe the dietary access modification you believe is necessary)

_____

_____

_____

_____

c. Explain how this alternative to the standard meal plan would affect the student's underlying condition. Please attach a separate sheet if more space is required.

_____

_____

_____

_____

d. Please list the diet/diets that the student should follow, including a sampling of foods the student can eat. Please attach a separate sheet if more space is required.

_____

_____

_____

_____

b. Recommended accommodations. Please provide a rationale for each accommodation. In the absence of a rationale, Student Disability Services may be unable to recommend the proposed accommodation:

_____

_____

_____

_____

c. Please provide any additional information you feel will be useful in determining the nature and severity of the student's disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:

_____

_____

d. **COURSE LOAD REDUCTION**: Is the student's condition such that it may require them to drop a course and/or take fewer than what is considered a full-time course load?

- ○ Yes
- ○ No
- ○ I don't know

If YES please explain: _____

_____

_____

Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information below. This form should be signed and returned via fax or mail to the SDS office at the address shown at the end of this document. ***All documentation submitted to SDS is considered confidential.***

Provider Information

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature:_____ Date:_____

Print name and title:_____

_____

State of License :_____ License Number: _____

Address:_____

_____

Street or P.O. Box City State Zip

Phone:_____ Fax:_____

Please return this form to:

University of Dallas
Student Disability Services
Academic Success Office 1845 East
Northgate Drive Irving, Texas 75062 Phone:
(972) 721-5056 Facsimile: (972) 265-5712

Attach Provider Business Card Here

[Adapted from https://diversity.utexas.edu/disability/wp-content/uploads/2018/07/Medical.VerForm-2015-Updated.pdf, with permission from ITS, The University of Texas at Austin, Austin, Texas 78712-1110.]