



UC SAN DIEGO EXTENSION
STUDENT SERVICES
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LA JOLLA, CALIFORNIA 92093-0176
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Documentation Form for ADD/ADHD

The student listed below has requested academic accommodations from Student Services at UC San Diego Extension.

In order for Student Services to determine eligibility and arrange for appropriate accommodations, your diagnosis and assessment of this student is required. Please complete this form in its entirety and return it to Student Services at UC San Diego Extension as quickly as possible. The Disability Coordinator will be unable to arrange appropriate accommodations for the student until completed documentation is received. All information will be kept confidential.

Attached is the "University of California Practices for the Documentation and Accommodation of Students with Attention-Deficit/Hyperactivity Disorder" to assist you in completing this form thoroughly and completely.

Student Name _____ DOB _____

Student ID Number _____

Name/Title of Certifying Professional (Please print) _____

License # _____ State _____

Address _____

Telephone Number _____ Fax Number _____

Signature _____ Date _____

TO BE COMPLETED BY STUDENT

Student Authorization:

I, _____, am requesting academic support services through UC San Diego Extension Student Services. They require current and comprehensive documentation of my disability/medical condition prior to receiving services through UC San Diego Extension. I acknowledge that by requesting academic accommodations, I am authorizing the UC San Diego Extension Student Services Disability Coordinator to discuss information relevant to my disability with my medical provider. I understand UC San Diego Extension will keep my information confidential as per UC Policy and Procedures Manual Section 160-2.

Student Signature: _____ **Date:** _____

9. Activities Assessment: Please check which of the activities are affected because of the diagnosis / impairment and indicate the level of limitation for each. For each activity, indicate if you observed it and/or if it was self-reported by the student. If not applicable, please check the box marked "N/A."

Activity	Level of Limitation				Observation		N/A
	Negligible	Mild	Moderate	Severe	Self-Reported	Medical Professional	
Organization							
Concentration							
Memory							
Time Management							
Stress Management							
Sleeping							
Social Interactions							
Attendance							
Managing Distractions							

10. Describe any medications and/or treatments currently being used by the student including type, dosage, effectiveness, and side effects. How frequently has medication/treatment been changed?

11. Explain how medication modifies the impact that the disability has on the student's condition.

12. Is the student compliant with his/her treatment plan? YES NO
13. Is the student compliant with medication/therapeutic protocols? YES NO
14. Is the student compliant with recommended referrals? YES NO

15. What is the student's prognosis?

16. Please attach any other supporting documentation including psycho-educational assessments or neurological evaluations.