Health-Related Disability Packet

This information submitted to Disability Services should reflect the most currently available information. This Health-Related Disability Packet should:

a) **Be completed by a qualified professional.**

b) **Be completed as clearly and thoroughly as possible.** Incomplete responses and illegible handwriting may require additional follow up.

c) **Be supplemented with reports or additional testing, if applicable.** Please do not provide case notes or test results without a narrative that explains the results.

Submit Information to:
Disability Services
Texas A&M University
1224 TAMU
College Station, TX 77843-1224
FAX: (979) 458-1214

PHONE: (979) 845-1637 (voice/relay)
Date: ____________________

Student Name: __________________________________________________    Birthdate: __________
          Last    First    M.I.

1. Date of first contact with this student: _______________________________
   Date of last contact with this student: _______________________________

2. List any disabilities including severity levels:
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

3. Please check all applicable impacts or symptoms of this student’s disability:
   ___ Low/High Blood Glucose Levels     ___ Seizures (Type: _____________________)
   ___ Anaphylaxis                        ___ Muscle Weakness
   ___ Hives/Rash                         ___ Nausea
   ___ Headaches                          ___ Vomiting
   ___ Light Sensitivity                  ___ Concentration/Attentional Difficulties
   ___ Aura/Visual Field Disturbance      ___ Sleep Disturbance (Type: _____________)
   ___ Fainting                           ___ Pain (List type & location of pain):
   ___ Dizziness                          __________________________________________
   ___ Brain Fog                          __________________________________________
   ___ Urgent/Frequent Restroom Use

   Please list any other impacts or symptoms that are not listed above:
4. Discuss any *side effects related to treatment or medications* that may be relevant to identifying accommodations.

5. Please state any *recommended academic accommodations* with a rationale.

6. Please *provide any additional information you feel is pertinent* or may be of use in the accommodation process.

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**Provider Information**

Provider Name (Print): _______________________________________________________________

Provider Signature: __________________________________________________________________

License or Certification #: ___________________________ State: ___________________

Address: __________________________________________________________________________

Phone: ___________________________ FAX: _______________________________________

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