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 Resources
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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