Health-Related Disability Packet

Disability Resources
DIVISION OF STUDENT AFFAIRS

This information submitted to Disability Resources 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
471 Houston Street; 1224 TAMU
College Station, TX 77843-1224

FAX: (979) 458-1214
EMAIL: disability@tamu.edu
PHONE: (979) 845-1637 (voice/relay)

If you want to send in medical documentation in a secure electronic format, you can use an encrypted file share service such as Filex (https://filex.tamu.edu) or WeTransfer (https://wetransfer.com) then send the link to the encrypted file and the decryption code to disability@tamu.edu.

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
____ Anaphylaxis
____ Hives/Rash
____ Headaches
____ Light Sensitivity
____ Aura/Visual Field Disturbance
____ Fainting
____ Dizziness
____ Brain Fog
____ Urgent/Frequent Restroom Use
____ Seizures (Type: _____________________)
____ Muscle Weakness
____ Nausea
____ Vomiting
____ Concentration/Attentional Difficulties
____ Sleep Disturbance (Type: _____________)
____ Pain (List type & location of pain):
____
____

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.

Provider Information

Provider Name (Print): ____

Provider Signature: ____

License or Certification #: _________________________________ State: __________________

Address: ____

Phone: _________________________________ FAX: ___________________________________