



Health-Related Physical Disability Documentation Form

This information submitted to the Office of Academic Support & Accessibility should reflect the most currently available information. **This Health-Related Disability Documentation Form must:**

- 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. A letter from the provider may be submitted but must addresses the same questions/topics in this packet.
- c) ***Be supplemented with reports which may include psycho-educational or neuropsychological reports.*** Please do not provide case notes or rating scales without a narrative that explains the results.
- d) Additional sheets may be included to expand on a particular question.

How to submit documentation:

- Submit medical documentation in a secure electronic format by using an encrypted file share service such as WeTransfer (<https://wetransfer.com>) and send the link to the encrypted file and the decryption code to academicsupport@lyon.edu.
- Scan and then upload into your Self Report prior to submitting the Self Report
- Deliver in person to
Lyon College
2300 Highland Road
Batesville, AR 72501

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:

<input type="checkbox"/> Low/High Blood Glucose Levels	<input type="checkbox"/> Seizures (Type: _____)
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Hives/Rash	<input type="checkbox"/> Nausea
<input type="checkbox"/> Headaches	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Light Sensitivity	<input type="checkbox"/> Concentration/Attentional Difficulties
<input type="checkbox"/> Aura/Visual Field Disturbance	<input type="checkbox"/> Sleep Disturbance (Type: _____)
<input type="checkbox"/> Fainting	<input type="checkbox"/> Pain (List type & location of pain): _____
<input type="checkbox"/> Dizziness	
<input type="checkbox"/> Brain Fog	
<input type="checkbox"/> 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.

Provider Information

Provider Name (Print): _____

Provider Signature: _____

License or Certification #: _____ State: _____

Address: _____

Phone: _____ FAX: _____