



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 address 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:

___ 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: _____