A student at Bard College at Simon’s Rock is requesting accommodations under the Americans with Disabilities Act on the basis of Attention-Deficit/Hyperactivity Disorder (AD/HD). This office requires current and comprehensive documentation of the student’s disorder from a qualified evaluator. The following professionals generally would be considered qualified to evaluate and diagnose AD/HD: licensed psychologists, neuropsychologists, psychiatrists, and other relevantly trained medical doctors. The provider completing this form cannot be a relative of the student. Specific information concerning the student’s condition and its impact on learning must be provided. Please fill out the form completely. Any questions should be directed to Jean Altshuler, Director of Accessibility and Academic Support at Bard College at Simon’s Rock at 413.528.7383 or jaltshuler@simons-rock.edu

STUDENT’S NAME: ______________________________________________________

Please respond to the following items regarding the student named above (Please print or type):

1. What is the student’s DSM IV-TR diagnosis? _________________________________________________________
   a. State the student’s current symptoms that meet the criteria for this diagnosis.
      __________________________________________________________________________________________
      __________________________________________________________________________________________
      __________________________________________________________________________________________
   b. State the age of onset of symptoms described by DSM IV-TR. ________________________________________
   c. What is the severity of the condition? __________________________________________________________
   d. State the frequency of your appointments and the date of your last contact with this student.
      _________________________________________________________________________________________

2. Describe the differential diagnoses that were excluded. State your reasons for considering these diagnoses, and your reasons for ruling them out. ________________________________________________________________
   _________________________________________________________________________________________
   _________________________________________________________________________________________
   _________________________________________________________________________________________
3. List and describe the measures used to support the student’s diagnosis. Neuropsychological or psychoeducational assessment is important in determining the current impact of the disorder on the individual’s ability to function in academically related settings. (Please attach report if available.)

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

4. Describe the symptoms related to the student’s condition that cause significant impairment in a major life activity.

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

5. List the student’s current medication(s), dosage, frequency, and adverse side effects.

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

a. Are there significant limitations to the student’s functioning directly related to the prescribed medications? YES ____________ NO ____________

b. If YES, please describe. ________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________
6. Please state specific recommendations regarding accommodations for this student, and a rationale as to why these accommodations are warranted based upon the student’s functional limitations.

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

8. If current treatments (e.g., medications) are successful, why are the above accommodations necessary?

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Certifying Qualified Evaluator (Cannot be a relative of student):

License #: ___________________________ State: ___________________________

Name: ___________________________ Phone #: ___________________________

Address: _____________________________________________________________________________________________

Email: ____________________________________________________________________________________________

Signature of Provider: ___________________________ Date: ___________________________

ALL DOCUMENTATION WILL BE HELD IN THE STRICTEST CONFIDENCE

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Great Barrington, MA 01230
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**Guidelines adapted from text created by Polly Waldman**