**Lagrange College Accessibility Verification Form**

Please return form to Lagrange College:

**Panther Academic Center for Excellence, Accessibility Services**

601 Broad Street Lagrange, GA 30240 | (706) 880-8652 | accessibility@lagrange.edu

<table>
<thead>
<tr>
<th>THIS SECTION MUST BE COMPLETED BY THE STUDENT</th>
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<tbody>
<tr>
<td>Student Last Name</td>
</tr>
<tr>
<td>Date Requested</td>
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<tr>
<th>THIS SECTION MUST BE COMPLETED BY A LICENSED PROFESSIONAL</th>
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This student may be eligible for services and accommodations at Lagrange College. In order to provide services, we must have verification of a disability diagnosis and limitations. The information you provide will be used for the sole purpose of determining eligibility for and authorization of accommodations at Lagrange College. Please complete a Verification Form for each diagnosed disability to ensure consideration of all aspects of the student's needs.

1. Diagnosis: ____________________________________________________________
   (If applicable, include DSM IV Code)

2. Date of Onset: ________________________ End Date or Re-Evaluation Date: ________________________

3. Severity:   [ ] Mild    [ ] Moderate    [ ] Severe    [ ] Other __________________________

4. Duration of Condition:
   - [ ] Permanent/Chronic
   - [ ] Temporary - give estimated duration ____________
   - [ ] Residual/Remission

5. Condition is:
   - [ ] Stable
   - [ ] Prone to exacerbations
   - [ ] Observable
   - [ ] Non-Observable

6. Prescribed Medication (s), Dosage and Side Effects: __________________________________________________________
   _______________________________________________________________________

7. Functional limitations of conditions and/or medication (i.e., the ways in which the diagnosis affects the student):
   - [ ] Attention and/or Concentration
   - [ ] Planning and/or Organization
   - [ ] Memory
   - [ ] Stamina
   - [ ] Mobility
   - [ ] Speaking
   - [ ] Sitting
   - [ ] Hearing - please attach audiogram
   - [ ] Writing
   - [ ] Processing Oral Materials
   - [ ] Vision: __________
   - [ ] Reading
   - [ ] Processing Visual Materials
   - [ ] Acuity: R________ L ________
   - [ ] Sleeping
   - [ ] Other _________________________

8. Please list other limitations or information helpful in determining necessary and appropriate auxiliary aids or services, academic adjustments or other accommodations in an educational setting:
   _______________________________________________________________________

I understand that the information provided in this form will become part of the student record subject to the Federal Family Education Rights and Privacy Act (FERPA) of 1974 and may be released to the student upon written request.

______________________  _________________________  _______________________
Signature of Verifying Licensed Professional  Title/License #  Date

______________________  _________________________  _______________________
Name (printed)  Address  Phone

________________________________________________________________________
AUTHORIZATION FOR RELEASE OF INFORMATION

Permission to release information to LaGrange College Counseling Records

I, ____________________________ (Student’s Name) give my permission to

&

(Name of Medical Provider) (Company of Medical Provider)

to disclose/exchange my medical information that is required for academic services and accommodation to

Lagrange College Counseling Center/Coordinator of Disability Services

Information to be released (circle all that apply)

_ ___written ___ verbal ___ email ___ phone

Use of the released information shall be limited to __________________________________________________________

This authorization is voluntarily given with my full realization that the records may contain confidential material. I understand I may revoke this consent at any time by notifying the Counseling Center in writing. I further release LaGrange College’s Counseling Center and the above-named organizations, institutions, and persons from all liability arising from the release of this information.

Consent for release of information shall be in effect from _____________ until ________________

Date                                   Date

___________________________                _______________________________

Signature of Student                    Signature of Witness

___________________________                _______________________________

Date                                   Date