

Grayson College Accessibility Services

Documentation for Housing Accommodations

Student Name: _____ Student ID#: _____

Filled out by Student

If this is a Housing request for an Assistance Animal, what type of animal are you requesting?

Dog Cat Other: _____

Note: All approved service or assistance animals must comply with applicable laws regarding animals, including the City of Denison Code of Ordinances, Chapter 4-Animals.

I authorize Grayson College Student Disability Services to receive documentation and speak to my current, licensed clinical professional or health care provider: _____

Student signature: _____ Date: _____

Disability Services at Grayson College complies with all federal and state disability laws to ensure equal access for qualifying persons with a disability to educational programs, services, and activities. Please complete the form below to assist Disability Services in determining appropriate and reasonable disability accommodations. To be considered for a housing accommodation due to a disability, Grayson College requires documentation of the student's current condition from the treating licensed clinical professional or health care provider. This provider must be thoroughly familiar with the student's condition and functional limitations and must make a direct connection to the requested accommodation based on the student's current functional limitations. This provider may not be a relative of the student, and the provider must be licensed within the student's home state or state of permanent residence where the student was diagnosed/treated. Please complete this form in total. Additional paperwork may be attached if the space provided is inadequate.

1. Date of Initial Contact with Student: _____/_____/_____.
2. **Specific Diagnosis/Disability:** Please list all relevant diagnoses, including DSM-IV or ICD Diagnoses (**text and code**), and Date of Diagnosis: _____/_____/_____.

3. Procedure/assessments used to diagnose this condition: (Attach copies of results)

4. Current severity/prognosis of this condition:

Severity of symptoms

- mild
- moderate
- severe

Prognosis of disorder:

- good
- fair
- poor

5. Date of last office visit with Student: _____/_____/_____

6. Prescribed treatment or medications:

7. Describe symptoms related to the student’s condition that cause significant impairment in a major life activity. Include how this limitation affects the student’s ability to participate in student life.

8. Please state the specific recommendation regarding housing/dining, and a rationale as to why these housing/dining needs are warranted based upon the student’s condition. Indicate why or how the recommended change(s) to the housing/dining environment are necessary. Recommendation must be clearly linked to functional limitations.

Thank you. This form should be signed and returned via fax or mail to the DS office at the address shown at the end of this document. All documentation submitted to DS is considered confidential.

Primary Professional Provider Information

By my signature below, I certify that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: _____ Date: _____

Print Name and Title: _____

Credentials _____ Specialty _____

State of License: _____ License #: _____

Address: _____

Phone: _____ Email: _____