TEXAS A&M **INTERNATIONAL** UNIVERSITY

Health-Related Disability Packet

Disability Services for Students

This information submitted to Disability Resources should reflect the most currently available information. **This Health-Related Disability Packet should:**

a) **Be completed by a qualified professional.**

b) **Be completed as clearly and thoroughly as possible.** Incomplete responses and illegible handwriting will require additional follow up.

c) **Be supplemented with reports or additional testing, if appropriate.** Please do not provide case notes or rating scales without a narrative that explains the results.

COVID-19 Update: While the university is minimizing in-person interactions and activities, Disability Resources is recommending that documentation and request forms NOT be sent by mail or fax since staff access to these communication mediums may be limited.

For any questions, contact our office at (956) 326-3086. Fax (956) 326-2231

Submit Information Electronically to:
disabilityservices@tamiu.edu

TEXAS A&M **INTERNATIONAL** UNIVERSITY

Date: ______________

Student Name: ____ DOB: ____________

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:

____
____
____
____
____

Severity: 1 = Mild 2 = Moderate 3 = Severe

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 related to identifying accommodations.

5. Please state any ***recommended academic accommodations*** with rationale.

6. Please ***provide any additional information you feel is pertinent*** or may be of use in the accommodation process.

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Provider Information

Provider Name (Print):____

Provider Signature: ____

License or Certification #: ___________________________ State: _____________

Address: ____

Phone: _____________________________ FAX: _________________________

Submit information electronically to:
disabilityservices@tamiu.edu

Confidential. For Professional Use.