ACCESSIBILITY RESOURCES
MINNESOTA STATE UNIVERSITY, MANKATO

Support for Students with Disabilities.
132 Memorial Library • Mankato, MN 56001
507-389-2825 (Phone) • 800-627-3529 (MRS/TTY) • 507-389-1199 (Fax)
www.mnsu.edu/access

DOCUMENTATION OF ADHD

Accessibility Resources' goal is to provide reasonable and effective accommodations for students with qualifying disabilities to support equal access to their education.

Eligibility for accommodations is determined by the individual's qualifications as a person with a disability. A disability is a physical or mental impairment that substantially impairs or restricts one or more major life activities. Documentation must be less than three years old.

Student Name: _____Tech ID#_____

Address: _____
_____

Disability/Diagnosis: _____

Last Contact Date: _____

Current Symptoms:

_____
_____
_____
_____

What methods and/or testing instruments were used to assess ADHD for this student?_____
_____
_____
_____
_____

Previous Academic Accommodations:

_____
_____
_____
_____

12.22.2021

Are ADHD medications are prescribed for this student? How do side effects of the medication impact learning?:_____

_____

_____

Assess degree of functional impairment due to ADHD demonstrated by this student: 1=Negligible 2=Moderate 3=Substantial 4=Severe UN=Unknown

1) Time Management	1	2	3	4	UN	1
2) Organizational skills (physical and/or cognitive)	1	2	3	4	UN	1
3) Task persistence	1	2	3	4	UN	1
4) Memory skills	1	2	3	4	UN	1
5) Reading (fluency, comprehension)	1	2	3	4	UN	1
6) Quantitative skills	1	2	3	4	UN	1
7) Written Expression	1	2	3	4	UN	1
8) Employment/work skills	1	2	3	4	UN	1
9) Self esteem/social skills	1	2	3	4	UN	1
10) Other Specify Here	1	2	3	4	UN	1

Suggested Accommodations: Healthcare Providers please provide suggestions for reasonable accommodations appropriate at the post-secondary level of education. Such accommodations should be supported by the assessment results and by the diagnosis. Accommodations must be reasonable and cannot fundamentally alter the basic nature or essential elements of an institution's courses or programs.

_____
_____
_____
_____
_____

In addition to this document, please attach the diagnostic summary report and any information that you feel is relevant in determining appropriate accommodations for this student.

Provider's Name: _____

Provider's Title/Credentials: _____

Provider's Signature: _____

Provider's/Clinic's Phone Number: _____

Date: _____

Please mail or fax the above information to Accessibility Resources at the address/ number listed above.

It is imperative we receive verification of the provider's authenticity. All documentation must include an official clinic stamp, original letterhead and/or fax cover sheet.

12.22.21