Student Name: ______________________________________ Student ID Number___________________________

FORM B: Medical Provider Information: Chronic Health Impairments **(This form is to be completed by a health professional only if the student has a documented medical need that requires special accommodations)**

Please complete the following information to assist Lebanon Valley College in determining your patient's need for Special Housing Accommodations. The information you provide will become a part of your patient's medical record at Lebanon Valley College and may be utilized by Student Services or Disability Services in accommodating your patients needs. Thank you for your assistance.

Consent for Release of Information: I, ____, give
Student Name

_______________________________________ permission to provide the information requested below to the
Medical Provider

Student Services staff and the Coordinator of Disability Services. I also understand that this information will become a part of my permanent medical record at the Shroyer Health Center.

____ ___________________________
Student Signature Date

A disability is defined under the Americans with Disabilities Act as "a physical or mental impairment that substantially limits a major life activity".

Examples of major life activities are: walking, speaking, breathing, hearing, seeing, thinking, sitting, sleeping, working, learning, interacting with others, concentrating, performing manual tasks, or caring for oneself.

1. Based on this definition does the individual have a physical or mental impairment?
   _____Yes _____ No

   If the answer to question 1 is yes, please answer the following questions:

   a. What specifically is the impairment?____

   b. Which major life activities are limited by the impairment?_______________________________________

   ____

   c. How many days/months did the impairment limit major life activities during the past year?

   ____

   ____

   d. What is the expected duration of the impairment?____

   ____

   e. What are the expected permanent or long-term effects of the impairment? _________________________

   ____

   f. Does the student take for this condition medication? _____Yes _____No

   If, yes please list: ____

   ____

   g. Does medication control/relieve the symptoms? _________________________________

2. If applicable, state how the condition currently impacts the student's ability to participate and learn.

___

___

___

3. If applicable, state specifically what academic accommodations you recommend.

___

___

___

4. If applicable, state specifically what special housing accommodations you recommend and what benefits these accommodations will have with regard to the individual's impairment.

___

___

___

5. Specify functional limitations related to the condition(s), i.e., length of time able to write, keyboard, walk, sit before needing a break and how long breaks should last before resuming activity.

___

___

___

6. Please list your recommended accommodations (e.g., accessible buildings, alternate format materials such as large print, Braille, assistive technology, or other.)

___

___

___

Medical Provider Name:___________________________ Date: ____________

Please Print

Medical Provider Signature: ___________________________

Return to: **Student Services Office**
Wagner House
Lebanon Valley College
101 North College Avenue
Annville, PA 17003-1400