Verification Form

Attention Deficit Hyperactivity Disorder

Bucks County Community College | Accessibility

Bucks County Community College's Accessibility Office (TAO) has established the Verification Form for Attention Deficit Hyperactivity Disorder (ADHD) to obtain current information from a licensed medical practitioner regarding a student's Attention Deficit Hyperactivity Disorder (ADHD) and its impact on the student and his or her need for accommodations. This Verification Form may supplement information that is provided in other reports, including medical reports, physiological assessments, or secondary school documentation. Any documentation, including this Verification Form, must meet Bucks County Community College's TAO guidelines for ADHD.

The person completing this form (after Section II) may not be a relative of the student or hold power of attorney over the student.

A summary of the guideline criteria for documenting ADHD is as follows:

1. A clinical history of ADD or ADHD
2. Symptoms of inattentiveness and/or impulsivity/ hyperactivity determined through the administration of objective measurements of attention and/or ADD or ADHD Rating Scales or Checklists
3. Functional impairment in one or more settings, including educational
4. Functional limitations affecting some important life skills, including academic functioning
5. Exclusion of alternative diagnoses and
6. Summary and recommendations

Section I: Student Information (Please type information or print legibly)

Student Name: _____ _____ _____
Last First Middle

Student ID: _____ **Date of Birth:** _____

Cell Phone: _____ **Home Phone:** _____

Bucks Email: _____ **Home Email:** _____

Permanent Street Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

(If different from Permanent Street Address)

Local Street Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

Section II: Provider Section (Please type information or print legibly)

A. Contact with the Student:

Date of initial contact with the student: _____

Date of last contact with the student: _____

B. Diagnosis Information:

1. Clinical History

Does the student have a clinical history (i.e., prior to age 12) of ADD or ADHD symptoms? ☐ **YES** ☐ **NO**

Approximately at what age did the student start to exhibit ADD or ADHD symptoms? _____

What date was the student diagnosed with ADD or ADHD symptoms? _____ _____
Month Year

2. Current Symptoms

a. Please check all ADHD symptoms that the student currently exhibits:

Inattention:	
☐	Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
☐	Often has difficulty sustaining attention in tasks or play activities.
☐	Often does not seem to listen when spoken to directly.
☐	Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked).
☐	Often has difficulty organizing tasks and activities.
☐	Often avoids, dislikes, or is reluctant to engage in tasks (such as schoolwork or homework) that require sustained mental effort.
☐	Often loses things necessary for tasks or activities (e.g., school assignments, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
☐	Is often easily distracted by extraneous stimuli.
☐	Is often forgetful in daily activities.

Hyperactivity:	
☐	Often fidgets with or taps hands or feet, or squirms in seat.
☐	Often leaves (or greatly feels the need to leave) seat in classroom or in other situations in which remaining seated is expected.
☐	Often runs about or climbs excessively in situations in which it is inappropriate (adolescents or adults may be limited to feeling restless).
☐	Often unable to play or take part in leisure activities quietly.
☐	Is often “on the go” or often acts as if “driven by a motor.”
☐	Often talks excessively.

Impulsiveness:	
☐	Often blurts out answers before questions have been completed.
☐	Often has difficulty awaiting turn.
☐	Often interrupts or intrudes on others (e.g., butts into conversations or games).

b. Is there clear evidence that the student’s ADHD symptoms are present in one or more setting including the educational environment?

School (classroom or educational setting):	
Home or work:	
With friends or relatives:	
In other activities:	

c. Is there clear evidence that the student’s ADHD symptoms are present in one or more setting including the educational environment?

School functioning:	
Social functioning:	
Work functioning:	

d. Did you use an objective measure of attention and/or a subjective ADHD Rating Scale or Checklist to obtain information about the student's symptoms and functioning in various settings? ☐ **YES** ☐ **NO**

1) If yes, which objective ADHD measurement and/or subjective ADHD Rating Scale(s) or Checklist(s) did you use?

2) If no, how did you reach your conclusion about the ADHD diagnosis and treatment?

3. ICD 10 Codes:

Please check the student's ICD 10 Code for ADHD Type	
☐	**F90.0** Attention-deficit hyperactivity disorder, predominantly inattentive type
☐	**F90.1** Attention-deficit hyperactivity disorder, predominantly hyperactive type
☐	**F90.2** Attention-deficit hyperactivity disorder, combined type
☐	**F90.8** Attention-deficit hyperactivity disorder, other type
☐	**F90.9** Attention-deficit hyperactivity disorder, unspecified type

4. World Health Organization Disability Assessment Schedule 2.0

a. Does the student have a WHODAS 2 Score? ☐ **YES** ☐ **NO**

b. If yes, please provide the score here: _____

5. Other Diagnosis and Student Behavioral History

a. Does the student have any other diagnosis? ☐ **YES** ☐ **NO**

b. If yes, please list the ICD 10 Codes and the diagnosis in the space provided below:

ICD 10 Code:	Diagnosis

c. Does the student have a clinical history of hospitalizations related to the diagnosed psychological disorder? ☐ **YES** ☐ **NO**

Number of times student was hospitalized: _____

1) Please provide information regarding the student's history of hospitalization(s).

d. Does the student have a clinical history of verbal or physical aggression toward peers, family members or adults? ☐ **YES** ☐ **NO**

1) Please provide information regarding the student's history of verbal or physical aggression.

e. Does the student have a clinical history of suicidal ideation or has the student attempted to take their own life? ☐ **YES** ☐ **NO**

1) Number of times student threatened suicide or has reported suicidal ideation: _____

2) Number of times student attempted suicide: _____

3) Please provide information regarding the student's history of suicidal ideation or suicide attempt(s).

6. Military Service

a. Has the student served in the military? ☐ **YES** ☐ **NO**

1) What branch of the military did the student serve with?

☐	United States Air Force	☐	United States Coast Guard	☐	United States Navy
☐	United States Army	☐	United States Marine Corp.		

b. Is the diagnosis related to their service in the military? ☐ **YES** ☐ **NO**

1) Please provide information regarding the student's history of psychological needs related to their military service.

c. Is the receiving treatment through United States Department of Veterans Affairs? ☐ **YES** ☐ **NO**

1) At what location of the VA does the student receive services? _____

C. Family History:

1. Does the student have a family history of physical health impairments? ☐ **YES** ☐ **NO**

2. If yes, please check all that apply:

☐	**Mother**	☐	**Father**	☐	**Siblings**
☐	**Grandparents (Maternal)**	☐	**Grandparents (Paternal)**	☐	**Aunts (Maternal)**
☐	**Uncles (Maternal)**	☐	**Aunts (Paternal)**	☐	**Uncles (Paternal)**
☐	**Cousins (Maternal)**	☐	**Cousins (Paternal)**		

a. If yes, please list the family history of any health disorders.

3. Does the student have a family history of any psychological disorders? ☐ **YES** ☐ **NO**

4. If yes, please check all that apply:

☐	**Mother**	☐	**Father**	☐	**Siblings**
☐	**Grandparents (Maternal)**	☐	**Grandparents (Paternal)**	☐	**Aunts (Maternal)**
☐	**Uncles (Maternal)**	☐	**Aunts (Paternal)**	☐	**Uncles (Paternal)**
☐	**Cousins (Maternal)**	☐	**Cousins (Paternal)**		

a. If yes, please list the family history of any psychological disorders.

D. Educational History:

1. Did the student receive special education or intervention services at the K-12 level? ☐ **YES** ☐ **NO**

2. If yes, please check all that apply:

☐	**Response to Intervention (RTI) Level 1**	☐	**504 Plan**
☐	**Response to Intervention (RTI) Level 2**	☐	**Other:**
☐	**Response to Intervention (RTI) Level 3**	☐	**Other:**
☐	**Individualized Education Program (IEP)**	☐	**Other:**

3. Did the student have a modified curriculum at the K-12 level? ☐ **YES** ☐ **NO**

**** A modified curriculum means that the student had alternative or different exams and assignments than their peers.***

E. Assistive Technology and Durable Medical Equipment:

1. Does the student use assistive technology? ☐ **YES** ☐ **NO**

a. If yes, please list the assistive technology.

2. Does the student use durable medical equipment? ☐ **YES** ☐ **NO**

a. If yes, please list the durable medical equipment.

D. Medication(s):

1. Is the student currently taking medication(s) for any symptoms related to the diagnosis? ☐ YES ☐ NO
2. Does the student have a history of noncompliance with medication? ☐ YES ☐ NO
   a. If yes, please list the behaviors or incidents of noncompliance with medication in the student's history.

3. If yes, please provide information below for each medication the student is currently prescribed:

Medication • Dosage • Frequency	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

E. Functional Limitations and Recommended Accommodations:

1. Please list the student's current ADHD symptoms and then indicate what reasonable academic accommodations would mitigate the symptom listed.

2. **Sample:**

Symptom: (Example)
Student has difficulty focusing on lectures and does not gain most information when taking notes.
Recommended Reasonable Accommodation(s):
Student will need assistance with notetaking. Student would benefit from the use of a LiveScribe pen, audio recording lectures or from receiving instructor notes.

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
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Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

Symptom:
Recommended Reasonable Accommodation(s):

Section III: Provider's Certifying Professional Information

(Please type information or print legibly)

Professionals conducting the assessment, rendering a diagnosis, and providing recommendations for reasonable accommodations must be qualified to do so (e.g., licensed physician, psychiatrist, clinical psychologist). The provider signing this form must be the same person answering the above questions. The person completing this form may not be a relative of the student or hold power of attorney over the student.

Provider Name: _____
Last First Middle

Credentials: _____

License Number: _____ **State of Licenser:** _____

Office Phone: _____ **Office Fax:** _____

Office Email: _____ **Office Website:** _____

Office Street Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

Provider Signature: _____ **Date:** _____

Section IV: Submitting This Form

It is the responsibility of the student to submit this form to the Learning Specialist in the Accessibility Office (TAO) at Bucks County Community College during their intake appointment when they register with TAO. Students will also be required to meet with a Learning Specialist if they would like to update their accommodations using the verification form or any other form of documentation.

Section V: How to Make an Intake Appointment

Students are encouraged to call or email the Accessibility Office (TAO) to schedule an appointment. Intake appointments are only done in person. There are certain times of year that appointment waiting times can be up to six weeks. The student identification number and Bucks email is required for students to obtain an intake appointment. Students are encouraged to contact TAO as soon as possible to ensure that their accommodations are approved and put into place as soon as possible. TAO's contact information is as follows:

Phone: (215) 968-8182

Email: accessibility@bucks.edu

Office: Bucks County Community College
275 Swamp Road
Rollins Center • Student Services Office • Room 001
Newtown, Pennsylvania 18940

Appointments can be scheduled for the Upper Bucks (Perkasie) and Lower Bucks (Bristol) campuses. TAO Learning Specialists are on each of the satellite campuses one day per week. The student should inform the TAO team member if they have a campus preference.

Information regarding the Accessibility Office (TAO), accommodations and assistive technology (AT) at Bucks County Community College can be found at https://www.bucks.edu/resources/campusresources/accessibility/. Please visit our website for the latest information and updates as they are made available. If you have any questions, please feel free to call us (215) 968-8182.