JACKSONVILLE UNIVERSITY

Disability Support Services
2800 University Blvd. N.
Jacksonville, FL 32211
Phone: (904) 256-7067 -- Fax: (904) 256-7066

Guidelines and Release Form

Welcome to the office of Disability Support Services (DSS) at Jacksonville University (JU). To be eligible for services at the DSS, a student must satisfy the definition of a disability as established by the Americans with Disabilities Act of 1973. **Section 504 defines a disability as a condition which substantially limits one or more major life activities such as learning, walking, seeing, hearing, breathing, caring for oneself, and working**. *To be eligible for accommodations, a student must provide appropriate documentation of each disability that demonstrates an accompanying substantial limitation to one or more major life activities.*

The following guidelines are provided in the interest of assuring that professionals' statement is appropriate to document eligibility for support services. The student with a disability must provide the office of DSS appropriate written documentation from a licensed professional in the field concerning the specific diagnosis and expected academic limitations.

The documentation must be within the last 3 years. However, the DSS reserves the right to make modifications to this time frame.

I,_____, hereby authorize the following information as well as any other pertinent documentation to be forwarded to the office of Disability Support Services at Jacksonville University for the purpose of determining my eligibility for academic accommodations.

Student's Signature:	Date:

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Note: we request our forms to be typed or handwritten in script form, to ensure legibility.

AUTISM SPECTRUM DISORDER DOCUMENTATION FORM

Student's Name:_____

Date of Birth: _____

The student named above is applying for disability accommodations and/or services through the Disability Support Services (DSS) at Jacksonville University. In order to determine eligibility, a qualified professional must certify that the student has been diagnosed as having Autism Spectrum Disorder/Asperger's Syndrome and must provide evidence that it represents a substantial impediment to a major life activity. It is important to understand that a diagnosis in and of itself does not substantiate a disability. This documentation form was developed as an alternative to a traditional diagnostic report.

- The form must be completed with as much detail as possible as a partially completed form or limited responses will hinder the eligibility process.
- The assessment information is current:
- For students just graduating high school, an evaluation reflecting current levels of academic skills should have been administered while in high school
- For students who have been out of school for a number of years, documentation will be considered on a case by case basis.
- Completed by a professional who has comprehensive training and direct experience in the differential diagnosis such as a psychologist, neurologist or psychiatrist.
- The professional completing the form is not a family member of the student or someone who has a personal or business relationship with the student.

1. What is the DSM-V diagnosis for this student?

   - Axis I:
   - Axis II:
   - Axis III:
   - Axis IV:
   - Axis V (GAF score):

2. Date of last contact with student: _____

3. How long has the student had this diagnosis/condition?

_____
_____
_____
_____

4. What are the student's primary current symptoms and concerns?

5. What is the severity of the symptoms?(please check one)

- (•) Mild
- ( ) Moderate
- ( ) Severe

Explain the severity indicated above:

6. Date(s) current assessment completed:

_____
_____
_____

7. State the frequency of appointments with student (e.g., once a week, twice a month):

_____
_____
_____

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8. **Psychological History** – Provide pertinent psychological history (include any psychological reports or testing utilized, if applicable): (attach supporting documents if needed)

9. **Psychosocial History –** Provide pertinent information obtained from the student/parent(s)/guardian(s) regarding the student's psychosocial history (e.g., history of not sustaining relationships, history of employment difficulties, history of educational difficulties, social inappropriateness, history of risk- taking or dangerous activities, etc.): (attach supporting documents if needed)

10. State the student's functional limitations from the disorder specifically in the college setting:

_____
_____
_____
_____
_____
_____
_____

11. Other pertinent information:

Please complete the following table based on the impact that the student's condition has on the particular activity of behavior:

Activity/Behavior	No Impact	Moderate Impact	Substantial Impact	Don't Know
Social interaction	☐	☐	☐	☐
Social awareness	☐	☐	☐	☐
Oral expression	☐	☐	☐	☐
Listening comprehension	☐	☐	☐	☐
Completing tasks	☐	☐	☐	☐
Organization	☐	☐	☐	☐
Distractibility	☐	☐	☐	☐
Adherence to strict routines	☐	☐	☐	☐
Sensory sensitivity	☐	☐	☐	☐
Repetitive behaviors	☐	☐	☐	☐
Time management	☐	☐	☐	☐
Mathematics	☐	☐	☐	☐
Reading	☐	☐	☐	☐
Writing	☐	☐	☐	☐
Other (please specify)				

12. List the student's relevant current medication(s), including dosage, frequency, and adverse side effects:

_____
_____
_____
_____
_____
_____

13. Provide an explanation of the extent to which the medication currently mitigates the symptoms of the condition:

_____
_____
_____
_____
_____
_____

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14. State specific recommendations regarding academic adjustments, housing accommodations, auxiliary aids, and/or services for this student and the reason these academic adjustments, housing accommodations, auxiliary aids, and/or services are warranted based upon the student's functional limitations.

_____
_____
_____
_____
_____

Certifying Professional:

Professional Signature:	Date:
Print Name, Title, Degree:	
Professional License Number:	
Company/Office/Institution Affiliation Name:	
Contact Information Address:_____ Phone #:_____ City, State, Zip: _____ Fax #: _____	

Please return any pertinent information to:

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