



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, Print Name , 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:
Student Id#:	



Visual Impairments & Blindness Documentation Guidelines

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

1. Diagnosis: Please list all diagnoses and supporting numerical assessments of vision.

Visual Acuity with correction: _____

Visual Acuity without correction: _____

a. Approximate onset of diagnosis

- Child – Approximate age: _____
- Adolescent – Approximate age: _____
- Adult – Approximate age: _____
- Unknown

b. Duration of disability/impairment:

_____ Permanent

_____ Temporary: Expected date of recovery: _____ Month/Year: _____

c. Date of your last clinical contact with student: _____/_____/_____

2. Evaluation

a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that might be helpful in determining eligibility for accommodations.

- Medical Evaluation (x-ray, lab work, EKG, etc.).
- Standard eye exam.
- Specialized eye exam: Specify _____
- Structured or unstructured interview with student.
- Interviews with other persons (i.e. parent, teacher, therapist).
- Behavioral observations.
- other (please specify): _____



b. Evaluation Results:

c. Present symptoms that meet criteria for diagnosis being noted:

d. Current treatment being received by student:

- Medication management

Current medications: _____

- Other (please describe): _____

e. Severity of symptoms:

- Mild
 Moderate
 Severe

f. Prognosis of disorder:

- Good (vision loss is stable)
 Fair (vision loss is changing but individual retains functional level of sight)
 Poor (vision is degenerative)



3. Functional Limitations

Please check below the major college life activities and academic functions listed below that are affected by the disability/impairment in a college setting, indicating the level of limitation.

Life Activity	Negligible	Moderate	Substantial
Walking			
Breathing			
Seeing			
Hearing			
Speaking			
Sitting			
Standing			
Eating			
Sleeping			
Performing Manual Tasks			
Learning			
Thinking			
Concentrating			
Memory			
Reading			
Writing			
Attending Class			
Meeting Deadlines			
Interacting with Others			
Other:			

4. Are there any situations or environmental conditions that might lead to an exacerbation of the condition?



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5. Please indicate your recommendations regarding academic accommodations and accompanying justifications for the student (e.g., note-takers, extended time for tests, etc.).

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Student Name:	
Professional Signature:	Date:
Print Name, Title, Degree:	
Professional License Number:	
Contact Information:	

Thank you for your prompt response to this request. Please return this information to:

Olga L. Florez, M.Ed., M.P.A
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