Housatonic Community College
Office of Disability Services
Medical Documentation

Your patient, _____, has disclosed his/her medical
Name Date of Birth
disabilities to the Office of Disability Support Services. The following information is required to validate this diagnosis and to determine the nature of appropriate and reasonable academic accommodations. This document must reflect the current impact on the student's academic functioning and support the requested accommodation(s) and/or auxiliary aid(s). Failure to provide this information will result in a delay or inability to provide the services. This College reserves the right to determine the nature and extent of reasonable and appropriate academic accommodations.

I. Current Medical Information

A. Medical diagnosis: _____

_____

B. Date of last appointment with undersigned professional: _____

C. Initial onset of symptoms: _____

_____

D. Description of present symptoms: _____

_____

_____

_____

_____

_____

E. Relevant historical and family data: _____

_____

_____

_____

_____

F. Treatment plan with medications: _____

_____

_____

_____

G. Prognosis and expected duration of treatment: _____

_____

_____

_____

H. Additional pertinent medical information with attached assessment tools and/or education testing with standardized scores: _____

_____

_____

_____

_____

II. Impact of Diagnosis in Education Setting

A. Current Functional academic limitations (please be specific):_____

_____

_____

_____

_____

B. Recommendations for academic accommodations that are realistic and validated by current documentation: _____

_____

_____

Additional Comments _____

_____

_____

_____

This information may be given to your client to submit to this Office, or you may forward it to the following:

Lynne Langella
Coordinator of Disability Support Services
Housatonic Community College
900 Lafayette Blvd.
Bridgeport, CT 06604

Questions or concerns may be directed to Lynne Langella at (203) 332-5018

_____	_____	_____
Name of professional (please print)	Title	Date
_____	_____	
Signature	Telephone Number	
_____	_____	
Street Address	City/State/Zip Code	