

**Center for Access-Ability Resources**  
Division of Student Affairs & Enrollment Management  
Northern Illinois University  
Health Services Building  
DeKalb, Illinois 60115  
Phone: (815) 753-1303/Fax: (815) 753-9570  
[www.niu.edu/caar](http://www.niu.edu/caar)

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**Attention Deficit Hyperactivity Disorder Documentation**

The student, whose name and signature appear below, has requested disability related services based on the diagnosis of an Attention Deficit Hyperactivity Disorder. The student is requesting that the following information be provide by a licensed professional trained in the area of ADHD. Please complete and return this form, and/or send copies of diagnostic evaluations and progress reports (containing the requested information), to the name and address listed above. Please consider this signed consent as authorization to release this information to the Center for Access-Ability Resources.

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Birthdate

\_\_\_\_\_  
ZID

\_\_\_\_\_  
Date

**Please note: Information provided is considered in determining appropriate disability relates resources, including academic accommodations.**

**DSM-IV-TR Diagnosis:**

**Date of Diagnosis** \_\_\_\_\_ **Date of last contact with student** \_\_\_\_\_ **Date of initial contact** \_\_\_\_\_

**Additional Assessment Instruments and Results:**

**Describe the Functional Impact** (cognitive, perceptual and physical abilities):

**List of Current Medication** (dosage, side effects):

**Treatment Plan** (please describe current treatment procedures, therapy, etc.):

**Recommendations for Accommodations and/or Resources:**

**Suggested Academic/Instructional Accommodations:**

- |   |  |
|---|--|
| <input type="checkbox"/> Note taking  | <input type="checkbox"/> Tape Recording Lectures             |
| <input type="checkbox"/> Time Extensions on Exams                           | <input type="checkbox"/> Low Distraction Testing Environment |
| <input type="checkbox"/> Preferential Classroom Seating                     | <input type="checkbox"/> Early Syllabus                      |
| <input type="checkbox"/> Classes scheduled around impact of ADHD medication |  |
| <input type="checkbox"/> Other (please specify) _____                       |  |

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**Credentials of Diagnosing Professional:**

_____ Signature of Certifying Professional	_____ Print Name/Title
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_____ License/Certification Number & State of Licensure	_____ Date
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\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

*Please direct any questions regarding completion of this form and the nature of information needed to a CAAR staff member at 815-753-1303. Return completed forms to: CAAR, Health Services 4<sup>th</sup> Floor, Northern Illinois University, DeKalb IL 60115*