Bucks County Community College

Verification Form

Attention Deficit Disorder & Attention Deficit • Hyperactivity Disorder

Bucks County Community College's Accessibility Office (TAO) has established the Verification Form for Attention Deficit Disorder & Attention Deficit • Hyperactivity Disorder (ADD & AD•HD) to obtain current information from a qualified practitioner (e.g., physician, psychiatrist, psychologist) regarding a student's ADD & AD•HD symptoms, related medications, and their impact on the student and his or her need for accommodations in the higher education classroom setting. This Verification Form may supplement information that is provided in other reports, including full neuropsychological or psychoeducational evaluations or secondary school documentation. Any documentation, including this Verification Form, must meet Bucks County Community College's TAO guidelines for ADD & AD•HD. **The person completing this form may not be a relative of the student or hold power of attorney over the student.**

A summary of the guideline criteria for documenting ADD & AD•HD can be found at the following web site: http://www.bucks.edu/student/accessibility/student-info/. A summary of the guideline criteria for documenting ADD or AD•HD is as follows:

1. A clinical history of ADD or AD•HD
2. Symptoms of inattentiveness and/or impulsivity and hyperactivity determined through the administration of objective measurements of attention and/or ADD or AD•HD 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:** _____

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 AD•HD symptoms? ☐ **Yes** ☐ **NO**

Approximately at what age did the student start to exhibit ADD or AD•HD symptoms? _____

What date was the student diagnosed with ADD or AD•HD symptoms? _____ _____
Month Year

2. Current Symptoms

a. Please check all ADD or AD•HD symptoms that the student currently exhibits:

Inattention: *(5+ checked for adolescents 17 and older indicates functional impairment)*	
	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: *(5+ checked in Hyperactivity and Impulsivity categories combined for adolescents 17 and older indicates functional impairment)*	
	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.

Inattention: *(5+ checked for adolescents 17 and older indicates functional impairment)*	
	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).

Other: *(Please list any additional documented impairments)*	

b. Is there clear evidence that the student's ADD or AD•HD symptoms are present in one or more setting, including the educational environment?

Hyperactivity: *(5+ checked in Hyperactivity and Impulsivity categories combined for adolescents 17 and older indicates functional impairment)*	
School (classroom or educational setting):	
Home or work:	
With friends or relatives:	
In other activities:	

c. Is there clear evidence that the student's ADD or AD•HD symptoms are interfering with or reducing the quality of at least one of the following, including academic functioning?

Hyperactivity: *(5+ checked in Hyperactivity and Impulsivity categories combined for adolescents 17 and older indicates functional impairment)*	
School functioning:	
Social functioning:	
Work functioning:	

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

e. If yes, which objective AD/HD measurement and/or subjective ADD or AD•HD Rating Scale(s) or Checklist(s) did you use?

f. If no, how did you reach your conclusion about the ADD or AD•HD diagnosis and treatment?

3. DSM Codes

Please include all pertinent diagnoses or rule-out diagnoses using DSM codes.	
Axis I:	
Axis II:	
Axis III:	
Axis IV:	
Axis V (GAF):	

C. Medications:

1. Is the student currently taking medication(s) for AD/HD symptoms? ☐ **Yes** ☐ **NO**

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

Medication • Dosage • Frequency (e.g., Adderall 5 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency (e.g., Adderall 5 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency (e.g., Adderall 5 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

D. Functional Limitations and Recommended Accommodations:

1. Please list the student's current ADD or AD•HD symptoms and then indicate what reasonable academic accommodations would mitigate the symptom listed. More detailed information regarding reasonable academic accommodations
2. **Sample:** Student has difficulty focusing on lectures and does not gain most information when taking notes.

Symptom: (Example)
Student has difficulty focusing on the lecture in the classroom. Student is easily distracted in the classroom.
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:
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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.

Provider's Name: _____
Last First Middle

Credentials: _____

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

Phone Number: _____ **Email:** _____

Practice Street Address: _____

_____

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

May this completed Verification Form be released to the student? ☐ **Yes** ☐ **NO**

Provider Signature: _____ **Date:** _____

Section IV: Submitting this Form

This form should be returned to the Accessibility Office (TAO) at Bucks County Community College where the student is enrolled. All forms need to be submitted at the Newtown campus. Please see the following methods of submission of this form:

Email: accessibility@bucks.edu

Fax: (215) 968-8033

USPS: Bucks County Community College
Attention: The Accessibility Office
275 Swamp Road
Newtown, Pennsylvania 18940

Physical Drop Off: Newtown Campus
Rollins Center • Student Services Office • Room 001

Information regarding the Accessibility Office (TAO) at Bucks County Community College can be found at http://www.bucks.edu/student/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.