Verification Form

Attention Deficit Hyperactivity Disorder



Bucks County Community College's Accessibility Office (TAO) has established the Verification Form for Attention Deficit Hyperactivity Disorder (ADHD) to obtain current information from a licensed medical practitioner regarding a student's mobility or upper extremity impairment and its impact on the student and his or her need for accommodations. This Verification Form may supplement information that is provided in other reports, including medical reports, physiological assessments, or secondary school documentation. Any documentation, including this Verification Form, must meet Bucks County Community College's TAO guidelines for ADHD.

The person completing this form (after Section II) may not be a relative of the student or hold power of attorney over the student.

A summary of the guideline criteria for documenting ADHD is as follows:

- 1. A clinical history of ADD or ADHD
- 2. Symptoms of inattentiveness and/or impulsivity/ hyperactivity determined through the administration of objective measurements of attention and/or ADD or ADHD 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

Student ID: Date of Birth: Cell Phone: Home Phone: Bucks Email: Home Email: Permanent Street Address: City: State: Zip: (If different from Permanent Street Address) 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: Date of last contact with the student: Date of last contact with the student: 1. Clinical History	Student Name:			
Cell Phone: Bucks Email: Home Email: Permanent Street Address: City: State: Zip: (If different from Permanent Street Address) 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:	Las	t First	Middle	9
Bucks Email: Permanent Street Address: City: State: Zip: (If different from Permanent Street Address) 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: Date of last contact with the student: 1. Clinical History Does the student have a clinical history (i.e., prior to age 12) of ADD or ADHD symptoms? YES NO Approximately at what age did the student start to exhibit ADD or ADHD symptoms?	Student ID:	Date of Birth:		
Permanent Street Address: City: State: Zip:	Cell Phone:	Home Phone:		
Address: City: State: Zip: (If different from Permanent Street Address) 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: Date of last contact with the student: Date of last contact with the student: Date of last contact with the student: Date of last contact with the student: Approximately at what age did the student start to exhibit ADD or ADHD symptoms? YES NO	Bucks Email:	Home Email:		
(If different from Permanent Street Address) 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: Date of last contact with the student: 1. Clinical History Does the student have a clinical history (i.e., prior to age 12) of ADD or ADHD symptoms? YES NC Approximately at what age did the student start to exhibit ADD or ADHD symptoms?				
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 ADHD symptoms? YES NC Approximately at what age did the student start to exhibit ADD or ADHD symptoms?	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 ADHD symptoms? YES NO Approximately at what age did the student start to exhibit ADD or ADHD symptoms?	Local Street			
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 ADHD symptoms? YES NO Approximately at what age did the student start to exhibit ADD or ADHD symptoms?	City:	State:	Zip:	
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 ADHD symptoms? YES NO Approximately at what age did the student start to exhibit ADD or ADHD symptoms?	Section II: Provider Section	(Please type information or print legibly)		
B. Diagnosis Information: 1. Clinical History Does the student have a clinical history (i.e., prior to age 12) of ADD or ADHD symptoms? Approximately at what age did the student start to exhibit ADD or ADHD symptoms?		ent:		
1. Clinical History Does the student have a clinical history (i.e., prior to age 12) of ADD or ADHD symptoms? Approximately at what age did the student start to exhibit ADD or ADHD symptoms?	Date of last contact with the stude	nt:		
	1. Clinical History	nistory (i.e., prior to age 12) of ADD or ADI	HD symptoms? YES	NO
What date was the student diagnosed with ADD or ADHD symptoms?	Approximately at what age did tl	ne student start to exhibit ADD or ADHD s	symptoms?	
	What date was the student diagr	nosed with ADD or ADHD symptoms?		

2. Current Symptoms

a. Please check all ADHD symptoms that the student currently exhibits:

Inattention:				
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.				

Ну	Hyperactivity:				
	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.				

Impulsiveness:			
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).		

b. Is there clear evidence that the student's ADHD symptoms are present in one or more setting including the educational environment?

School (classroom or educational setting):	
Home or work:	
With friends or relatives:	
In other activities:	

c. Is there clear evidence that the student's ADHD symptoms are present in one or more setting including the educational environment?

School functioning:	
Social functioning:	
Work functioning:	

	Verification Form:	Attention Deficit Hy	peractivity Disorde
--	--------------------	-----------------------------	---------------------

		Verification Form: Attention Deficit Hyperactivity	Disorder
	d.	Did you use an objective measure of attention and/or a subjective ADHD Rating Scale YES or Checklist to obtain information about the student's symptoms and functioning in various settings?	NO
		1) If yes, which objective ADHD measurement and/or subjective ADHD Rating Scale(s) or Checklist you use?	(s) did
		2) If no, how did you reach your conclusion about the ADHD diagnosis and treatment?	
3.	_	O 10 Codes:	1
	P	ease check the student's ICD 10 Code for ADHD Type	
		F90.0 Attention-deficit hyperactivity disorder, predominantly inattentive type	
		F90.1 Attention-deficit hyperactivity disorder, predominantly hyperactive type	
		F90.2 Attention-deficit hyperactivity disorder, combined type	
		F90.8 Attention-deficit hyperactivity disorder, other type	
		F90.9 Attention-deficit hyperactivity disorder, unspecified type	
4.		orld Health Organization Disability Assessment Schedule 2.0	
	a.	Does the student have a WHODAS 2 Score?	NO
	b.	If yes, please provide the score here:	
5.	Ot	her Diagnosis and Student Behavioral History	
		Does the student have any other diagnosis?	NO
	b.	If yes, please list the ICD 10 Codes and the diagnosis in the space provided below:	
		ICD 10 Code: Diagnosis	
	c.	Does the student have a clinical history of hospitalizations related to the diagnosed YES psychological disorder?	NO
	c.	psychological disorder?	NO
	c.	psychological disorder? Number of times student was hospitalized:	NO
	c.	psychological disorder?	NO
	c.	psychological disorder? Number of times student was hospitalized:	NO
	c.	psychological disorder? Number of times student was hospitalized:	NO
	c.	psychological disorder? Number of times student was hospitalized:	NO
	c.	psychological disorder? Number of times student was hospitalized:	NO NO
		psychological disorder? Number of times student was hospitalized: 1) Please provide information regarding the student's history of hospitalization(s). Does the student have a clinical history of verbal or physical aggression toward peers, family members or adults?	
		psychological disorder? Number of times student was hospitalized: 1) Please provide information regarding the student's history of hospitalization(s). Does the student have a clinical history of verbal or physical aggression toward YES	
		psychological disorder? Number of times student was hospitalized: 1) Please provide information regarding the student's history of hospitalization(s). Does the student have a clinical history of verbal or physical aggression toward peers, family members or adults?	

						Verification Form:	Atter	ntion Deficit	Hyperact	ivity Disorde
e. Does the student have a clinical history of suicidal ideation or has the student YES attempted to take their own life?						NO				
			1)	Number of times student threat suicidal ideation:	ene	ed suicide or has reported				
			2)	Number of times student attem	pte	d suicide:				
			3)	Please provide information regar	•		al ide	ation or su	icide atte	empt(s).
	6.		Has	/ Service the student served in the military What branch of the military did t		student serve with?			YES	□ NO
				United States Air Force		United States Coast Guard		United Sta	ates Navy	/
				United States Army		United States Marine Corp.				
		.		e diagnosis related to their service. Please provide information regar service.		•	logic	al needs re	YES	L NO their militar
								_		
		c.	s the	e receiving treatment through Un At what location of the VA does		·	Affa	irs?	YES	NO
C.			es t	ory: he student have a family history of please check all that apply:	of p	hysical health impairments?			YES	NO NO
	ے.			other	T	Father		Siblings		
				andparents (Maternal)		Grandparents (Paternal)		Aunts (Ma	ternal)	
	Uncles (Maternal) Aunts (Paternal) Uncles (Paternal)									
			Со	usins (Maternal)		Cousins (Paternal)				
	Г	a.	If ye	es, please list the family history of	f an	y health disorders.				

	, , ,		<u> </u>				
	Uncles (Maternal)	Aunts (Paternal)	Uncles (Paternal)				
	Cousins (Maternal)	Cousins (Paternal)					
a.	a. If yes, please list the family history of any health disorders.						
			4				

Verification Form: Attention Deficit Hyperactivity Disorder

	3.	Does the student have a family history	y of any psychological o	disorders?	YES	NO
	4.	, , , ,			T	
		Mother	Father		Siblings	
		Grandparents (Maternal)	Grandparents (Pa	ternal)	Aunts (Maternal)	
		Uncles (Maternal)	Aunts (Paternal)	.	Uncles (Paternal)	
		Cousins (Maternal)	Cousins (Paternal	•		
	Г	a. If yes, please list the family history	of any psychological di	sorders.		
D.	_	cational History:		.:+ + / 42		
	1.	Did the student receive special education	on or intervention serv	rices at the K-12 i	evel? YES	NO
	2.	If yes, please check all that apply:				
		Response to Intervention (RTI) Le	evel 1	504 Plan		
		Response to Intervention (RTI) Le	evel 2	Other:		
		Response to Intervention (RTI) Le		Other:		
		Individualized Education Program		Other:		
	_			•		
	3.	Did the student have a modified curricu			YES	NO
		* A modified curriculum means that the st	uaent naa aiternative oi	aijjerent exams a	na assignments than the	eir peers.
Ε.	Ass	istive Technology and Durable Medical	Equipment:			
	1.	Does the student use assistive technol	logy?		YES	NO
		a. If yes, please list the assistive techn	nology.			
	_					
	2.	Does the student use durable medical	equipment?		YES	NO
	_	a. If yes, please list the durable medic	al equipment.			

Medication(s):					
. Is the student currently taking medication(s) for any symptoms related to the diagnosis? YES NO					
. Does the student have a history of noncompliance with medication? YES NC					
a. If yes, please list the behaviors or incidents of noncompliance with medication in the student's history.					
2. If you who so we wide information below for each modification the student is suggestful processited.					
3. If yes, please provide information below for each medication the student is currently prescribed: Medication ● Dosage ● Frequency					
Date Prescribed:					
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):					
Medication • Dosage • Frequency					
Date Prescribed:					
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):					
Medication • Dosage • Frequency					
Date Prescribed:					
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):					
Medication ● Dosage ● Frequency					
Date Prescribed:					
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):					
Medication Dosage Frequency					
Date Prescribed:					
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):					
Medication • Dosage • Frequency					
Date Prescribed:					
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):					

D.

_	Eunctional	Limitations	and Pacam	Mondod A	ccommodations
ъ.	Functional	Limitations	and Recom	ımended A	ccommodations

Recommended Reasonable Accommodation(s):

1.	Please list the student's current ADHD symptoms and then indicate what reasonable academic accommodations
	would mitigate the symptom listed.

Student has difficulty focusing on lectures and does not gain most information when taking notes.

Sample:

Symptom: (Example)

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:
Recommended Reasonable Accommodation(s):
Symptom:
- оутронт.
Recommended Reasonable Accommodation(s):
Symptom:
оутрын. Потрыент
Recommended Reasonable Accommodation(s):
Symptom:
Recommended Reasonable Accommodation(s):
Symptom:
- 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. The person completing this form may not be a relative of the student or hold power of attorney over the student.

Provider Name:				
	Last	First		Middle
Credentials:				
License Number:		State of Licenser:		
Office Phone: Office Email:		Office Fax:		
		Office Website:		
Office Street				
Address:				
City:		State:	Zip:	
Provider Signature:			Date:	

Section IV: Submitting This Form

It is the responsibility of the student to submit this form to the Learning Specialist in the Accessibility Office (TAO) at Bucks County Community College during their intake appointment when they register with TAO. Students will also be required to meet with a Learning Specialist if they would like to update their accommodations using the verification form or any other form of documentation.

Section V: How to Make an Intake Appointment

Students are encouraged to call or email the Accessibility Office (TAO) to schedule an appointment. Intake appointments are only done in person. There are certain times of year that appointment waiting times can be up to six weeks. The student identification number and Bucks email is required for students to obtain an intake appointment. Students are encouraged to contact TAO as soon as possible to ensure that their accommodations are approved and put into place as soon as possible. TAO's contact information is as follows:

Phone: (215) 968-8182

Email: accessibility@bucks.edu

Office: Bucks County Community College

275 Swamp Road

Rollins Center • Student Services Office • Room 001

Newtown, Pennsylvania 18940

Appointments can be scheduled for the Upper Bucks (Perkasie) and Lower Bucks (Bristol) campuses. TAO Learning Specialists are on each of the satellite campuses one day per week. The student should inform the TAO team member if they have a campus preference.

Information regarding the Accessibility Office (TAO), accommodations and assistive technology (AT) at Bucks County Community College can be found at https://www.bucks.edu/resources/campusresources/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.