JOLIET JUNIOR COLLEGE

STUDENT ACCOMMODATIONS & RESOURCES

1215 Houbolt Road
Joliet, IL 60431
(815)729-9020 Ext. 2230
FAX (815)280-2820

CERTIFICATION OF ATTENTION DEFICIT DISORDER

The student named below has applied for services from the Student Accommodation and Resources (StAR) at Joliet Junior College. In order to determine eligibility for services, we need documentation of the students Attention Deficit/ Hyperactivity Disorder (ADHD). After completing this form, please mail or FAX it to StAR at the address above. The information you provide will not become of the student's educational records and will be kept in the student's confidential file at StAR. In addition to the requested information, please attach any additional information: for example, your report and any test results. Thank you for your assistance.

1. Date:______________ Date of Birth:________________________

   Name of student:____

2. What is your DSM-IV multi-axial diagnosis for this student? (Reference DSM-IV, p.25)

Axis I: Clinical Disorders

Axis II: Personality Disorders, Mental Retardation

Axis III: General Medical Conditions

Axis IV: Psychosocial and Environmental Problems

Axis V: Global Assessment of Functioning

2. On what date did you make this diagnosis:_______________________________________

3. In addition to DSM-IV criteria, how did you arrive at your diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine which accommodation and services are appropriate for the student.

Structured or unstructured interviews with the person himself or herself. ☐

Interviews with other persons. ☐

Development history. ☐

Educational history. ☐

Medical history. ☐

Neuro-psychological testing. Date(s) of testing ☐

Psycho-educational testing. Dates(s) of testing? ☐

Standardized or UN-standardized rating scales. ☐

DSM-III-R diagnostic criteria. ☐

DSM-IV diagnostic criteria. ☐

Other (please specify). ☐

5. Is this student taking medication(s) for ADHD? Describe medication(s), dates(s) prescribe, effect of academic functioning, and side effects.

6. In your opinion, what functional limitations does this student encounter as a result of his/her ADHD provide specific information about limitations when the student is using medication and when the student is not using medication.

7. Is there anything else you would like us to know about this student?

Signature of Professional	Date
Professional/s Name (printed) and Title	License Number
Street Address	Telephone Number
City, State, Zip Code	Fax Number