

MORAVIAN UNIVERSITY

Medical Condition Documentation

The Accessibility Services Center (also referred to as the ASC) complies with federal and state disability laws that prohibit discrimination and equal access for qualified persons with disabilities to educational programs, services, and activities. Medical providers must complete this form to assist the ASC in determining eligibility, appropriate and reasonable disability accommodations. ***The medical provider cannot be a family member, friend, or relative of the student. Please print legibly.***

Student's First and Last Name: _____

Condition Information:

Date of initial contact with the student: _____

What is the student's medical condition? _____

When was the condition first diagnosed? _____

What is the frequency of appointments? _____

Date of the last visit for the condition: _____

Indicate the severity of the condition: Mild Moderate Severe. Please explain below.

What is the expected duration of the condition?

Short-term (less than six months)

Episodic

Long-term (6 months – 1 year)

Chronic (longer than one year)

Select all that apply to this student:

The student is not ambulatory.

The student cannot negotiate stairs.

The student requires an elevator.

The student received emergency room treatment for this condition within the last year.

Date(s) treated: _____

The student received in-patient treatment for this condition within the last year.

Date(s) treated: _____

Accessibility Services Center | 1200 Main Street | Bethlehem, PA 18018

T: 610 861-1401 | F: 610 625-7877 | asc@moravian.edu | www.moravian.edu/accessibility

Medication Information:

Is the student currently taking medication? Yes No Does not apply.

If yes, please provide information on each medication below:

Medication 1:

Name of Medication: _____

Date Prescribed: _____

Side effects: _____

Medication 2: Not applicable.

Name of Medication: _____

Date Prescribed: _____

Side effects: _____

Medication 3: Not applicable.

Name of Medication: _____

Date Prescribed: _____

Side effects: _____

Medication 4: Not applicable.

Name of Medication: _____

Date Prescribed: _____

Side effects: _____

Diagnosis Procedures/Assessment:

How did you arrive at your diagnosis? *Please attach copies of the assessment results if applicable.*

Current Symptoms:

List the student's current symptoms:

How do the symptoms affect the student's academic engagement?

Functional Limitations:

Describe how the above condition substantially limits a significant life activity that the average person in the general population can perform with little or no difficulty.

How does the student's condition impact their daily life experience in the post-secondary setting, such as in academics, communal living/dining, recreation, etc.?

What are the recommendations for health care and symptom management for the above conditions while on campus?

Please use additional pages should you need more space to explain the requested information.

Medical Provider Information:

What is the role of the medical provider? _____

Provider's Full Name: _____ Practice Name: _____

Provider's Street Address: _____

City: _____ State: _____ ZIP Code: _____

License or Certification: _____ State: _____ Specialty: _____

Phone Number: _____ Fax Number: _____ Email: _____

Provider's Signature: _____ Date completed: _____

Please attach a copy of the medical provider's business card to this form.

Student's Section and Release:

The ASC encourages students to sign this form and submit it along with the documentation completed by their medical provider. Signing and submitting this release will expedite the communication between the ASC and the medical provider, avoiding delays in the accommodation process.

I, _____ (print the student's first and last name), certify the following:

- My medical provider completed this form.
- I authorize my medical provider to release the medical information requested on this form to the ASC so that they can determine appropriate accommodation(s) for my condition(s).
- I give the ASC permission to communicate with my medical provider and to discuss the information contained in this form.
- I understand that if I do not have my medical provider complete this form and consult with the ASC, it may result in significant delays in processing accommodations.

Student Signature: _____ Date Form Completed: _____

Form Submission:

Do not submit medical documentation via email but use one of the secure methods listed below.

- The documentation can be faxed securely to (610) 625-7877.
- Upload the PDF securely by visiting <http://bit.ly/ascdocumentation>.
- The student may upload the completed PDF by doing the following:
 - Log in to [Accommodate](https://moravian-accommodate.simplicity.com) (<https://moravian-accommodate.simplicity.com>)
 - Click on **Documents**
 - Click on **Approved Documents**
 - Click on **Add New**
 - Complete the form.