ALBRIGHT COLLEGE 1856

Office of Student Accessibility and Advocacy
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Verification Form: Vision Impairments

Rev. 10.10.2023

Albright College's Student Accessibility and Advocacy office (SAA) has established verification forms to assist in obtaining current information from a qualified professional (e.g., Medical Physician, Neurologist/ Neuropsychologist, Clinical Psychologist, Licensed Counselor, or other relevant provider) regarding a student's condition and symptoms. This form should be filled out by a licensed professional treating this individual for at least three months. To assist the student, we need to understand the student's symptoms, relevant medications and their impact on the student, and the student's need for accommodations. This Verification Form may supplement information provided in other reports, including medical reports or secondary school documentation. It is not a replacement for a full evaluation or test scores.

Any documentation must meet Albright College's documentation standards for the student's condition. A summary of the criteria for documenting a disability is listed below. Complete information can be found in the Albright College's Documentation Standards which is provided to the student. If you would like a copy of the standards, please call our office.

- Documentation must show evidence of a disability as defined by the ADAA.
- Documentation must be no more than 3 years old except in rare circumstances.
- Documentation must describe functional impairment affecting an important life skill and how this affects the student in the college environment.
- Documentation must provide history relevant to the student's disability, including treatments, assistive devices, or other pertinent information.
- Documentation must establish a clear link between the recommended accommodation and the student's functional limitations.
- Documentation must present a summary and recommendations.

*(Please **print legibly** or **type**; illegible documents will not be processed)*

Student Information

Student's Name: ____ DOB: _________________________

Home Address: ____

Local Address (if different): ____

Cell Phone: ___________________________________ Other Phone: __________________________________

Provider Section

Date of Initial Contact with Student: ____________________________

Date of Most Recent Contact with Student: ______________________

Diagnosis

What is the student's primary diagnosis?____ DSM-5: ___________

Descriptive Features: ____

When was the student diagnosed with THIS condition (MM/YYYY)? ______________________________

How long have you been treating the student for THIS condition? ______________________________

How often is the student seen for THIS condition? (e.g., weekly, monthly) ________________________

What is the severity of the impairment? ☐ Mild ☐ Moderate ☐ Severe

Explain how you determined the severity above: ____

____

____

How was the student diagnosed/what diagnostic tools or tests were used?

(Please submit results with this form) ____

____

____

Do you consider the student to have a disability? ☐ Yes ☐ No

*(Please **print legibly** or **type**; illegible documents will not be processed)*

Diagnosis (cont'd)

What is the expected duration of the impairment?

☐ Short-term (less than six months)

☐ Episodic

☐ Long-term (six months to one year)

☐ Chronic (more than one year, with frequent recurrences)

Please explain why the above duration was chosen: ____

____

Current Symptoms

What is the student's best corrected visual acuity and visual field in each eye?

Visual Acuity (20/XX)

Distance OS: ______________________________ OD: __________________________________

Near OS: _________________________________ OD: __________________________________

Visual Field (XX degrees)

Central OS: _______________________________ OD: __________________________________

Peripheral OS: ____________________________ OD: __________________________________

Is the student's vision expected to remain stable or is it expected to decline? ☐ Stable ☐ Decline

If it is expected to decline, please describe how you anticipate the vision loss to progress:

____

____

Describe the proficiency of orientation and mobility of the student for independent travel (e.g., uses a guide dog, has usable vision, uses GPS or other technology): ____

____

____

*(Please **print legibly** or **type**; illegible documents will not be processed)*

Current Symptoms (cont'd)

Is there clear evidence that the symptoms associated with the student's diagnosis interfere with or reduce the quality of at least one of the following within the academic environment? (Please explain in the space provided.)

Academic Functioning: ____

____

____

Social Functioning: ____

____

____

Workplace Functioning: ____

____

____

Is there any other historical information related to the student's impairment that you feel is necessary to consider? (e.g., medical, psychological, developmental) ____

____

____

____

*(Please **print legibly** or **type**; illegible documents will not be processed)*

Pharmacology and Side Effects

Is the student taking any prescribed medications for the diagnosis that you are treating or any other medication that may impact the student's ability to function in the college environment? ☐ No ☐ Yes

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

Medication/Dosage/Frequency: ____

Date First Prescribed: ____

Side effects that impact the student's functioning (e.g. concentration, sleep, eating):

____

____

Medication/Dosage/Frequency: ____

Date First Prescribed: ____

Side effects that impact the student's functioning (e.g. concentration, sleep, eating):

____

____

Medication/Dosage/Frequency: ____

Date First Prescribed: ____

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____

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Medication/Dosage/Frequency: ____

Date First Prescribed: ____

Side effects that impact the student's functioning (e.g. concentration, sleep, eating):

____

____

*(Please **print legibly** or **type**; illegible documents will not be processed)*

Functional Limitations and Recommended Accommodations

It is important for us to understand how the student's current symptoms may cause functional impairments in a college environment. Accommodations are not based on the student's diagnosis or medication, but rather on the limitations of their functioning in the educational environment. Based on your knowledge of the student, please provide information regarding reasonable academic accommodations and the rationale for each accommodation based on the student's symptoms.

Symptom: ____

How does this affect the student? ____

____

____

Recommended reasonable accommodation: ____

____

____

Symptom: ____

How does this affect the student? ____

____

____

Recommended reasonable accommodation: ____

____

____

Symptom: ____

How does this affect the student? ____

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____

Recommended reasonable accommodation: ____

____

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*(Please **print legibly** or **type**; illegible documents will not be processed)*

Assistive or Adaptive Technology

Are glasses or other visual aids prescribed to assist the student's visual acuity? ☐ No ☐ Yes

If yes, what is prescribed and what is the visual acuity with this aid? ___________________________________

____

____

What does the student use to access print (e.g., enlarged typeface, Braille, test reader, screen reader)?

____

If the student currently uses assistive or adaptive technologies to facilitate visual performance, please list the specifics related to the technology and the setting in which it is used (e.g., home, school, work):

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____

____

____

*(Please **print legibly** or **type**; illegible documents will not be processed)*

Provider's Certifying Information

Professionals rendering assessments and diagnoses and providing recommendations for reasonable accommodations must be relevant and qualified to do so (e.g., medical doctor, neurologist/neuropsychologist, psychologist, licensed counselor). The provider signing this form must be the same person who answered the questions above and may NOT be related to the student.

Provider's Signature: ____ Date: __________________________

Provider's Name: ____

Credentials: ____

License Number: ____

State of Licensor: ____

Office or Business Name: ____

Office or Business Address: ____

Office Phone: ____________________________________ Fax: ____

Email Address: ____

Directions for Submitting This Form and Supporting Documentation

This form is not a substitute for evaluation or testing data. Please submit this form, along with the student's most current evaluation, test results/scores, and other supporting documents directly to the SAA Office. Documentation should be faxed to us at 610-929-6793 or mailed to us at:

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