# Disability Verification Form for Traumatic Brain Injury (TBI)

Purpose: The student named below has indicated that s/he has a disability and will require reasonable accommodations to participate in a program or activity at Kean University. The information you provide will be one of the criteria used to evaluate the student’s eligibility for the requested accommodations or services. Please complete this form in its entirety. All information provided will be kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).

## **Student Information:**

|  |  |
| --- | --- |
| Student’s First Name: |  |
| Student’s Last Name: |  |

## The remainder of this document must be completed by a certified/licensed Health Care Provider.

Date of First Diagnosis: Click or tap to enter a date.

Date Student was first seen: Click or tap to enter a date.

Date Student was last seen: Click or tap to enter a date.

## **TBI Information**

In order to help this student adapt to college life after his/her injury, please supply (in as much detail as possible) answers to the questions that follow. Please complete all items which you have a history or have assessed in the course of clinical evaluation. If you wish to, please attach any relevant reports. At the end of this form, please hit submit and attach any items.

Date of Injury: Click or tap to enter a date.

|  |  |  |
| --- | --- | --- |
| Number of Concussions **with** loss of consciousness: | |  |
|  | |  |
| Number of Concussions **without** loss of consciousness: | |  |
|  | |  |
| Date(s) without loss of consciousness: |  | |

Were there any hospitalizations associated with any of these injuries? Yes  No

Were there any surgeries required as a result of any of these injuries? Yes  No

If you answered yes to any of the above, please provide details here:

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| --- |
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## **Post-Concussive Status**

Indicate all conditions present now: (Check all that apply)

|  |  |  |
| --- | --- | --- |
| Fatigue | | Amnesia |
| Attention Problems | | Confused Periods |
| Balance Problems | | Seizures |
| Dizziness | | Personality Change |
| Noise Sensitivity | | Irritability |
| Light Sensitivity | | Behavioral Problems |
| Headaches | | Anxiety |
| Sleep Problems | | Depression |
| Memory Problems | | Suicidal Tendencies |
| Other: |  | |

Please check if any or all of the following were done and provide the reports:

Skull X-ray

EEG

CT/MRI

SPECT

Please provide as attachments, any reports from neuropsychological/educational testing relating to TBI or any items listed in the section above.

## **Medication**

Is the student currently taking any medication?  Yes  No

If yes, please provide information on each medication below:

(e.g., Celebrex, 200 mg, 1x daily, 1/1/2020, Dr. John Doe)

Medication 1, Dosage, & Frequency

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Date Prescribed** | **Prescribing Physician** |
|  |  |  |  |  |
| Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.): | | | | |
|  | | | | |
|  | | | | |

**Medication 2, Dosage, & Frequency**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Date Prescribed** | **Prescribing Physician** |
|  |  |  |  |  |
| Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.): | | | | |
|  | | | | |
|  | | | | |

**Medication 3, Dosage, & Frequency**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Date Prescribed** | **Prescribing Physician** |
|  |  |  |  |  |
| Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.): | | | | |
|  | | | | |
|  | | | | |

**Medication 4, Dosage, & Frequency**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Date Prescribed** | **Prescribing Physician** |
|  |  |  |  |  |
| Side effects that impact the student’s functioning (e.g., concentration, sleep, thinking, eating, etc.): | | | | |
|  | | | | |
|  | | | | |

## **Functional Limitations**

Please comment on the particular problems that may impair this student's functioning in the post-secondary school environment (e.g. the students/patient has difficulty functioning in the morning) and elaborate on present symptoms checked in the post-concussive status.

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**Health Care Provider Completing this form:**

Role of the individual completing this form (check all that apply).

|  |  |  |
| --- | --- | --- |
| Medical Doctor | | Neuropsychologist |
| Physical Therapist | | Occupational Therapist |
| Speech Language Pathologist | | Rehabilitation Nurse |
| Other: |  | |

|  |  |
| --- | --- |
| Facility/Company Name:  Provider Full Name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| License Number: |  |
| Title/Profession: |  |
| Street Address: |  |
| City, State, Zip |  |
|  |  |
| Phone Number: |  |
| Fax Number: |  |
| E-mail Address: |  |

|  |  |
| --- | --- |
| Provider Signature: |  |

**Today’s Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **PROVIDER – Please include office stamp for authentication. If your office does not use an office stamp, please indicate this below in the stamp here box. Include copies of evaluation and diagnostic evaluations reports for each area of disability.**
* **PROVIDER AND STUDENT – This Disability Verification Form serves as proper medical documentation for the above mentioned student. If for any reason, this form cannot be completed, the Kean University Office of Accessibility Services cannot implement services for this student. Please contact us with any questions at (908) 737-4910 or** [**accessibilityservices@kean.edu**](mailto:accessibilityservices@kean.edu)

**Please return this form to the student for submission.**

Stamp Here: