Missouri Valley College
Accessibility/Disability Services
Medical Release Form

SECTION A: STUDENT INFORMATION (Completed by the student)

INSTRUCTIONS: Complete student information and healthcare provider information, and sign authorization release below. Please send this form to your healthcare provider. Make additional copies of this form for each of your healthcare providers, if you have more than one provider.

Student Name:___________________________________Student ID#_____________________

Date of Birth____________________Email:____

Home Address:____

Local Address:____

Home Phone #__________________________________Cell Phone #_____________________

________ I hereby authorize Missouri Valley College to receive information from the provider below. I also authorize my provider to discuss my condition(s) with the appropriate Missouri Valley College (MVC) personnel on an as-needed basis.

________ I hereby authorize the Accessibility and Disability Services Office for MVC to communicate directly with the health care provider who completes this form to obtain clarification of issues relating to the functional limitations for which I am seeking the accommodation of an Emotional Support Animal.

Provider Name:____

Address:____

City:___________________________________State:__________________Zip:_____________

Phone Number:____

Student Signature:______________________________ Date___________________________

SECTION B: HEALTHCARE PROVIDER (Completed by Healthcare provider)

DOCUMENTATION GUIDELINES:

Acceptable documentation must reflect the following:

- Current documentation (in most cases, within 18 months)
- A specific diagnosis
- Specific findings in support of all diagnoses
- A description of the student's functional limitations as they are directly related to the stated disability
- Specific recommendations for accommodations for curriculum, instruction, testing and/or physical accessibility

INSTRUCTIONS:
To properly evaluate how Missouri Valley College can best meet the student's need for reasonable accommodations, the College requires specific diagnostic information from a licensed clinical professional or healthcare providers. The professional provider should be a regular provider to the psychological conditions(s). The provider completing this form cannot be a relative of the student. The provider should completely respond to all questions. Additional related information may be attached.

Student's Full Name____Birthdate:______/______/______

To determine the eligibility for ADA Accommodations under The Americans with Disabilities Act (ADA) of 1990, Missouri Valley College of Marshall, Missouri requests current and comprehensive documents of the student's condition from a licensed clinical professional or healthcare provider that is familiar with the history and functional limitations of the student's condition(s).

1. Student's disability/diagnosis:

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2. When was the condition(s) first diagnosed?____
3. How would you describe the severity of this condition(s)?________________________________
4. How long is this condition(s) likely to persist? ____
5. When was the student/patient last seen by you?_______________________________________
6. When is the next follow up visit or telehealth visit scheduled?______________________________
7. What treatment or medication has been prescribed?____________________________________

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8. Does the student's disability/health condition significantly limit any major life activities? If yes, please describe the limitations and/or restrictions in detail.

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9. Is this disability/health condition temporary?______ If yes, give ending date ______________

10. Please state specific recommendations regarding the accommodations(s) this student needs and explain why such an accommodation is warranted based upon the student's physical or psychological condition(s):

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All fields below must be completed to process documentation.

Signature of Provider____ Date______________

License #____ State____________

PRINT Name and Title:____

Address____

Phone:_____________________________________Email:___________________________

COMPLETED FORM SHOULD BE FAXED OR EMAILED BY HEALTHCARE PROVIDER TO:

Debbie Coleman
Director of Accessibility and Disability Services
Missouri Valley College
Fax # 660-831-4233
Email: colemand@moval.edu

CONFIDENTIALITY NOTICE: Medical related information shall be kept confidential and maintained separate from other personnel records. However, supervisors and managers may be advised of information necessary to the determinations they are required to make in connection with a request for an accommodation. First aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment or if any specific procedures are needed in the case of fire or other evacuations. Government officials investigating compliance with the ADA may also be provided relevant information as requested.