



**DISABILITY VERIFICATION  
Epilepsy (Seizure) Disorder**

*Please read the following prior to completing this form:*

Student Accessibility Services at Kent State University provides support services to students with diagnosed disabilities, including serious medical conditions and chronic health disabilities. To ensure the provision of reasonable and appropriate accommodations for our students, this office requires **current, within the past 6 months to 1 year, and comprehensive documentation of the disorder from their licensed physician who is currently treating the seizure disorder.** This should include information that describes the symptoms and manifestation of the condition, medication prescribed, and recommendations for treatment.

*\*NOTE: Student Accessibility Services (SAS) reserves the right to make appropriate modifications to the above time frame required for current documentation when necessary.*

For additional information about SAS please visit: [www.kent.edu/sas](http://www.kent.edu/sas)

Please provide the following information about (student name): \_\_\_\_\_

1. Diagnosis: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_ Last contact with student: \_\_\_\_\_

Is the student/patient currently under your care? \_\_\_\_\_ YES \_\_\_\_\_ NO

2. Are the student/patient's **seizures currently active?** \_\_\_\_\_ YES \_\_\_\_\_ NO  
If seizures are active, **how often do the seizures occur?** \_\_\_\_\_

\_\_\_\_\_

3. Please **describe the type and severity of seizures** the student/patient experiences: \_\_\_\_\_

\_\_\_\_\_

4. List **current medication(s), dosage, frequency and possible adverse side effects** as related to academic performance: \_\_\_\_\_

\_\_\_\_\_

5. List any **other treatment(s)** the student is receiving to manage his/her condition: \_\_\_\_\_

\_\_\_\_\_

6. Describe the student/patient's **symptoms and/or behaviors that occur prior to or during a seizure:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. What is the **approximate recovery period** for the student/patient after experiencing a seizure? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
8. Describe the **student/patient's prognosis** for this condition: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
9. Describe how this medical condition **substantially limits a major life activity** and **how it may impact the student's progress** in an academic setting: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
10. List any **recommendations for accommodations** you have for this student in an academic setting:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
11. Please describe any specific concerns you may have, or other ways that we may be of further assistance to this student: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Healthcare Provider Information**

Provider Name and Title: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_ Cell Phone: (     ) \_\_\_\_\_

\*NOTE: Cell phone number will only be used in case of emergency

The information you provide in this document is maintained in the office of Student Accessibility Services at Kent State University according to the guidelines of the Family Educational Rights and Privacy Act (FERPA).

**Please mail or fax this completed form to:**

Student Accessibility Services • Kent State University • Ground Floor, DeWeese Center • Kent, OH 44242  
**Phone:** (330) 672-3391 **Fax:** (330) 672-3763 **Email:** sas@kent.edu