PADUA FRANCISCAN HIGH SCHOOL

Counseling Department Needs Verification Form

Padua's Counseling Department utilizes an interactive, case-by-case approach when determining eligibility for services and reasonable accommodations. Students requesting accommodations from Padua are required to provide documentation regarding their diagnosed impairment(s) and its educational impact.

Appropriate documentation should include, but is not limited to, the following:

1. Completed by a licensed or properly credentialed professional (e.g. medical doctor, psychiatrist, psychologist, counselor, speech/language pathologist, etc.)
2. All sections of the Needs Verification Form should be thoroughly completed.
3. Any prior assessment results.

The information provided on the Needs Verification Form is maintained by the Counseling Department according to the guidelines of the Family Education Rights and Privacy Act (FERPA, 1974).

Please note, a previous IEP/SEGO/504/Accommodation, while helpful in establishing a record of supported accommodations, may not be enough to establish the presence of a disability at the high school level.

For incoming students: we will need this form completed thoroughly and have an observational period during the first quarter where we will utilize teacher assessments in determining what is the best course of action to meet a student's needs at the high school level.

Please contact the Counseling Department at (440) 845-2444 with questions. Thank you for your assistance.

STUDENT INFORMATION
(To be completed by parent)

First Name:_____ **Last Name:**_____

Status: (Circle one): **Current Student** **Prospective Student**

Phone: (_____) _____-_____ **Email:**_____

I authorize the following individual or organization to release the information included in this document to Padua Franciscan High School's Counseling Department:

Name/Title:_____ **Phone: (_____) _____-_____**

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Parent Signature:_____ **Date:**_____

DIAGNOSTIC INFORMATION
(To be completed by medical practitioner/specialist)

1. Please specify the specific diagnosis(es)/disability. For psychological disabilities, please indicate both the name of the diagnosis, and the diagnostic taxonomy used.

Diagnostic taxonomy used: DSM-V ICD-10

If applicable, rate the level of severity of the diagnosis? Mild_____ Moderate_____ Severe_____

Duration of condition: Permanent_____ Temporary (specify length of time) _____

Date of Diagnosis:_____ Date of last contact with Student_____

2. How did you arrive at your diagnosis? Please check all relevant items below. If applicable, please attach the diagnostic reports and/or test results administered to determine diagnosis.

- Behavioral Observations/Development History ☐
- Medical History ☐
- Structured/unstructured student interview ☐
- Neuro-Psychological Testing/Dates ☐ _____

_____

- Rating Scales/Dates (specify) ☐ _____

_____

- Psycho-Educational Testing/Dates ☐ _____

_____

- Other (specify) ☐ _____

_____

3. Please indicate the level of impact the student's needs may have in limiting the following major life activities:

Life Activity	No Impact	Negligible Impact	Moderate Impact	Substantial Impact	N/A
Attending class regularly					
Caring for Oneself					
Communicating					
Concentrating					
Hearing					
Interacting with Others					
Interacting Socially					
Learning					
Making/keeping appointments					
Managing Distractions					
Managing Stress					
Meeting Deadlines					
Memorizing					
Organization					
Performing Manual Tasks					
Reading					
Seeing					

Life Activity	No Impact	Negligible Impact	Moderate Impact	Substantial Impact	N/A
Sleeping					
Thinking					
Writing					
Other:					

4. For the major life activities checked on the previous page, please provide an explanation of the functional impact of the limitation in an academic setting:

5. If applicable, please describe the relevant history of remediation (e.g. previous/current medications, side effects of medications, other treatment plans and their effectiveness):

6. Please list any recommendations for accommodations you have for this student in an academic setting, if applicable. (Please note, recommendations will be considered in the evaluation process, however final decisions will be determined by the Padua Franciscan High School Staff):

7. Please provide any additional information that you think would be useful to know in working with this student:

HEALTHCARE PROVIDER INFORMATION

I attest to the accuracy of the information contained in this document. Additionally, I understand that the information provided in this document will become a part of the student's record subject to the Family Education Rights and Privacy Act (FERPA) of 1974, and may be released to the student/parent upon written request.

Provider Name (PRINT):_____

Provider Signature:_____Date:_____

Title:_____

License or Certification #_____National Provider Identifier (NPI):_____

Address:_____

City:_____ State:_____ Zip:_____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

Please contact the Padua Franciscan Counseling Department with questions.

Please mail, fax, or email this completed form to:

Padua Counseling Department* 6740 State Rd.*Parma, OH 44134

Phone: (440) 845-2444 x 101* **Fax:** (440) 845-5710***Email:** mholzheimer@paduafranciscan.com

***Adapted from Kent State University Student Accessibility Services Disability Verification Form