Verification Form for Low Vision/Blind Disabilities
Calvin College

Services to students with disabilities, as part of the Center for Student Success strives to ensure that qualified students with low vision/blind disabilities are accommodated and if possible that these accommodations do not jeopardize successful therapeutic interventions. The office does not modify requirements that are essential to the program of instruction or provide accommodations for persons whose impairments do not substantially limit one or more major life function.

Calvin College is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide effective services for qualified students with documented disabilities if such accommodations are needed to provide equitable access to the College programs and services. Federal law defines a disability as a physical or mental impairment that substantially limits one or more major life activities. Major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. It is important to note that a low vision/blind condition in and of itself does not necessarily constitute a disability. The degree of impairment must be significant enough to substantially limit one or more major life activities.

This form is designed to allow us to achieve these goals. Students who wish to receive academic adjustments due to a low vision/blind disability need to have this form filled out by an ophthalmologist. The professional completing this form must have first hand knowledge of the students’ condition, must have experience diagnosing and treating college students and will be an impartial professional who is not related to the student.

Release of Information
I, __________________________, hereby authorize the exchange and release of the following confidential information to the Center for Student Success and Calvin College for the purpose of determining my eligibility for educational accommodation.

_________________________________________  _____________________________
Date                      Student’s Signature

Student Information (This section to be completed by the student)
Last Name ______________________ First Name ______________________ MI __
Student ID# ______________________ Date of Birth ______________________
Address ___________________________ Phone ___________________________
City ___________________________ State ________________ Zip Code ____________

Certifying Professional
Name ___________________________
Credentials _______________________
Address ______________________

STUDENT NAME: ___________________________________________
Verification Form for Low Vision/Blind Disabilities

City __________________________ State _______________ Zip Code _______________________
Phone ________________________ Fax ________________________
License/Certification number and state of license ________________________________
Signature: ______________________________________________________________________
Date of initial contact with student ____________ Date of last contact ________________

**Diagnosis:**

________________________________________________________________________________

Date of Diagnosis ____________
Basis on which diagnosis was made __________________________________________
________________________________________________________________________________

Current medications including dosage and side effects ____________________________
________________________________________________________________________________

Long-term treatment plan ______________________________________________________
________________________________________________________________________________

Current compliance with treatment plan: Yes □  No □  Other ______________________
Prognosis for treatment plan (Include likelihood of improvement or further deterioration and within what approximate time frame.) ________________________________
________________________________________________________________________________

Planned therapeutic interventions______________________________________________
________________________________________________________________________________

Prognosis for therapeutic interventions (Include likelihood for improvement or further deterioration and within what approximate time frame.) ________________________________
________________________________________________________________________________

Current compliance with therapeutic interventions: Yes □  No □  Other ______________
History of hospitalization _______________________________________________________
________________________________________________________________________________

**Implications for Educational Success**

Learning abilities specific to the post-secondary environment that are impaired by the disability. (e.g. difficulty with concentration, slow processing speed, etc.)
________________________________________________________________________________
________________________________________________________________________________
Implications for taking exams and other classroom activities caused by the disability or medications. Please describe and explain why:

Suggested accommodations  Each recommended accommodation should include a detailed explanation of its relevance to the disability that is diagnosed. Evaluator also should indicate the level of impaired functioning at which the individual is currently functioning even with the benefits of treatment. Please send a report from an ophthalmologist.

(Final determination of appropriate accommodations will be determined by our office in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws.)

This form should be returned to:

Calvin College
Center for Student Success
Attn: Disability Services
1820 Knollcrest Circle SE
Grand Rapids, MI 49546

Phone #: (616) 526-6155
Fax #: (616) 526-7066