SMC STAR CHRONIC HEALTH CONDITION FORM

TO BE COMPLETED BY MEDICAL PROVIDER

Student Information:

Name: _____

Student's Email: _____

SMC ID Number: _____

Student's Cellphone Number: _____

Medical Provider Information:

Medical Provider's Name: _____

Medical Provider's Degrees(s) and Specialties:

_____

_____

Medical Provider's Phone Number: _____

Medical Provider's Address: _____

_____

Medical Provider's License Number/ State of Licensure: _____

_____

CHRONIC MEDICAL CONDITION INFORMATION:

Diagnosis: _____

_____

Approximate Date(s) of Onset: _____

_____

Date of your last clinical contact with the student: _____

Which methods did you use to arrive at the student's diagnosis; i.e., testing, lab work, x-rays, interview with student, etc.? _____

_____

_____

Severity of symptoms **WITH** mitigation:

____ Mild ____ Moderate ____ Severe ____ Other: _____

_____

Severity of symptoms **WITHOUT** mitigation:

____ Mild ____ Moderate ____ Severe ____ Other: _____

_____

Frequency and duration of symptoms of student's condition:

____ Daily ____ 1-3 times per week ____ 1-3 times per month

____ 1-3 times per year ____ None—symptoms under control with medication/treatment

____ Other: _____

What is the student's current treatment? How frequently does the student receive treatment? What medications, if any, are used to treat the student, and what are their side effects? _____

_____

_____

In what ways does the disability substantially impact the student's functional abilities? Please consider areas such as the classroom, student housing, homework, and assignments. _____

_____

_____

As the student's medical provider, what accommodations do you recommend for the student to have equal access to the College's programs and services? _____

_____

_____

Will you continue seeing the student for follow-up appointments?

____ Yes ____ No ____ Other: _____

If yes, when is the next appointment? _____

Is there any other pertinent information that you wish to share to assist Spartanburg Methodist College in providing accommodations to the student? _____

_____

_____

Your signature below certifies that you are the person who has completed this form and that you are not related to the student by blood or through marriage. In addition, you attest that all the information you have provided is accurate and current.

Signature of Medical Provider: _____

Completion Date of Form: _____