



**Office of Student Affairs  
Documentation of Medical, and/or Psychological Condition, and/or Disability for Academic  
Accommodations, Housing Accommodations, Meal Plan Exemptions, and/or Parking Permits.**

The student should complete the top part of this form and then ask a licensed health care or and/or educational professional to provide the remaining information. **The professional completing this form may not be related to the student.**

**To be completed by the student:**

Student Name: \_\_\_\_\_ Student ID #: \_\_\_\_\_

I am (please check one):

a current Lake Forest College student  an incoming new/transfer student

I am requesting (check all that apply):

Housing Accommodation  Meal Plan Exemption\*  Parking Permit  Academic Accommodation

I request the following information from my health care and/or educational professional be used as documentation of my request for accommodation. I understand this documentation may be reviewed and discussed with members of the Special Accommodations Committee as appropriate. I understand that a member of the Special Accommodations Committee may contact me for further information and/or discuss options related to my request(s). Furthermore, I give my consent for the appropriate clinician or licensed professional on behalf of Lake Forest College to contact the professional for additional information as needed.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

e-mail: \_\_\_\_\_ Phone: \_\_\_\_\_

**\*Note: Exemptions from the meal plan are only granted when there are documented restrictions that Aramark Dining Services is unable to accommodate.**



3. How is the student impacted by the condition? How will the requested accommodation reduce the effects that the student's disabilities may have on academic performance and life functioning?
  
4. What recommendations do you have regarding accommodations/exemptions to ameliorate the described barriers? Please include rationale.
  
5. List current treatments and accommodations, including therapy, assistive devices and medication (including dosage and frequency).
  
6. Please include any other information that may help us accommodate this student.

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

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

**Send to:**

Dr. Jennifer Jeziorski-Fast  
Lake Forest College

**Provider's Clinic Stamp or  
License Number Here:**

(non-licensed professionals should include a  
business card)

555 N. Sheridan Rd  
Lake Forest, IL 60045  
fax: 847-735-6098