MONTGOMERY
COUNTY COMMUNITY COLLEGE

Concussion Documentation Form

TO BE COMPLETED BY MEDICAL DOCTOR/NEUROLOGIST/OTHER QUALIFIED DIAGNOSTICIAN*

(*as specified in College Guidelines)

The student below has reported that they sustained a concussion within the past six months and will require accommodations to participate in Montgomery County Community College's events or programs. Concussion and Mild Traumatic Brain Injury (mTBI) are used interchangeably for the purpose of this form. Please fill this form out completely. **The Office of Disability Services is responsible for and will make final determinations of accommodations.**

STUDENT, PLEASE COMPLETE THE SECTION BELOW:

Student's name _____ **Student's Date of Birth** _____

I _____ **give permission for the release of information to**
(Signature of student)
Disability Services for the purpose of determining academic accommodations.

PROFESSIONAL, PLEASE COMPLETE ALL ITEMS BELOW:

Date of concussion(s): _____

Level of severity of symptoms (please check): Mild ____ Moderate _____ Severe ____

Any prior concussions (please check): Yes _____ No _____

If so, when? What was the level of severity: _____

Date of last appointment with student: _____

Date of re-assessment appointment with student (if applicable): _____

Check all relevant functional limitations are **substantially** limited

_____Working _____Sleeping _____ Caring for self _____ Interacting with others

_____Learning _____Memory _____Concentration _____ Vision _____ Auditory

____ Other(s) Please explain:_____

Assessments (e.g., psychometric, imaging) used to evaluate effects of concussion (please attach scores/results):

_____

_____

Please describe this how each functional limitation will affect the individual's ability to participate fully in the post-secondary environment:

_____

_____

_____

Have you any recommendations regarding accommodations to equalize this student's educational opportunities at the post-secondary level? Each recommended accommodation must have a clear nexus to one or more functional impairments; describe if not obvious.

_____

_____

Is this student currently on medication that may impact his or her performance in the educational setting?

Yes ____ No____ If yes, please explain:_____

_____

Anticipated duration for need of the accommodations described above (date and/or time frame from concussion onset): _____ _____

Other comments. _____

_____

Please attach any other information relevant to this student's social and academic adjustment at the College.

Please note that the Office of Disability Services is responsible for and will make all final determinations of reasonable accommodations.

Signature of diagnostic practitioner: _____ Date:_____

Type of License:_____State of License and No.:_____

Print name and title:_____

Address: _____

Telephone: _____ Fax: _____ Email:_____

This form will be uploaded by the student to be sent to our office VIA a Secure File Transfer link. If you wish to send a copy to the Office of Disability Services, please use our Secure File Transfer link (https://sft.mc3.edu/filedrop/disabilities) or fax 215-619-7174. If faxed, please include a cover sheet with student's name and birthdate.

Office of Disability Services
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