DES MOINES UNIVERSITY

**Center for Educational Enhancement**

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# Clinical Checklist for Temporary Medical Accommodations

CEE uses this checklist to determine appropriate accommodations for a student's temporary medical condition. The student's health care provider completes this form.

**Required:** Attach a signed and dated physician's confirmation letter. The letter must be printed on the physician's official letterhead and contain the doctor's name, specialty, address, and phone number.

## TYPE OF INJURY OR CONDITION

☐ Arm or Hand
☐ Leg or Foot
☐ Head
☐ Other (list): _____

Full description or details of the condition:

Date of onset: _____ Anticipated date of recovery:_____

Date of next professional follow-up visit: _____

Describe how the condition affects mobility or range of motion:

Can student perform timed tasks?

☐ Yes
☐ No
☐ Limited: _____

Table 1: Medications taken for injury, impairment or condition

| Medication name | Rx or OTC | Dose | Frequency | Start Date | Reason for taking |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Relevant side effects: _____

Table 2: Impact on function in several areas.

| Area | None | Mild | Moderate | Substantial |
|---|---|---|---|---|
| Breathing | ☐ | ☐ | ☐ | ☐ |
| Seeing | ☐ | ☐ | ☐ | ☐ |
| Hearing | ☐ | ☐ | ☐ | ☐ |
| Walking | ☐ | ☐ | ☐ | ☐ |
| Standing | ☐ | ☐ | ☐ | ☐ |
| Working | ☐ | ☐ | ☐ | ☐ |
| Manual tasks | ☐ | ☐ | ☐ | ☐ |
| Memory | ☐ | ☐ | ☐ | ☐ |
| Managing distractions | ☐ | ☐ | ☐ | ☐ |
| Regular class attendance | ☐ | ☐ | ☐ | ☐ |
| Quantitative reasoning | ☐ | ☐ | ☐ | ☐ |
| Eating | ☐ | ☐ | ☐ | ☐ |
| Reading | ☐ | ☐ | ☐ | ☐ |
| Talking | ☐ | ☐ | ☐ | ☐ |
| Writing | ☐ | ☐ | ☐ | ☐ |
| Sitting | ☐ | ☐ | ☐ | ☐ |
| Sleeping | ☐ | ☐ | ☐ | ☐ |
| Lifting or carrying | ☐ | ☐ | ☐ | ☐ |
| Concentrating | ☐ | ☐ | ☐ | ☐ |
| Interacting with others | ☐ | ☐ | ☐ | ☐ |
| On time assignments | ☐ | ☐ | ☐ | ☐ |
| Processing speed | ☐ | ☐ | ☐ | ☐ |

Table 3: Current symptoms

| Symptom | Frequency | Duration | Intensity |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Arm or Hand**

Dexterity: ☐ None ☐ Full ☐ Limited:_____

Affected arm or hand: ☐ Left ☐ Right ☐ Both

Mobility device required: ☐ None ☐ Cast ☐ Splint ☐ Sling

Table 4: Performance using arm or hand

| Performance | Yes | No | Limited |
|---|---|---|---|
| Can type or write: | ☐ | ☐ | ☐ Explain: _____ |
| Can perform physical exams: | ☐ | ☐ | ☐ Explain: _____ |
| Can properly manipulate medical equipment: | ☐ | ☐ | ☐ Explain: _____ |

Restrictions: _____

**Leg or Foot**

Ambulatory: ☐ Yes ☐ No ☐ Limited:_____

Which leg or foot: ☐ Left ☐ Right ☐ Both

Mobility device required:

☐ Scooter
☐ Walker
☐ Cane
☐ Walking Boot
☐ Wheelchair: Indicate Manual or Electric
☐ Crutches: Indicate one or two
☐ Other:_____

**Ability to stand or ambulate**

Length of time: ☐ Normal ☐ Limited:_____

Weight bearing: ☐ Yes ☐ No weight bearing ☐ Limited:_____

Assistance required: ☐ Yes ☐ No

**Ability to sit**

Length of time: ☐ Normal ☐ Limited:_____

Extremity elevated: ☐ N/A ☐ Anytime sitting ☐ Intermittent

Restrictions:_____

**Concussion or Brain Injury (Traumatic or Acquired)**

Explain the nature of the head injuries:

How does the head condition impact student's daily life?

Restrictions or limitations due to the head condition:

## RECOMMENDATIONS

Additional information, recommendations, and suggested accommodations:

Physician Name (Print): _____ Phone: _____

Physician Signature: _____ Date: _____