STUDENT SIGNED CONSENT FOR RELEASE OF INFORMATION
(Print or Type)

Name (Last, First, Middle): _____

Date of Birth:_____ NSHE: _____

Status (check one):
Current UNLV student
Transfer student
Prospective student

Local phone: (_____)-_____-_____

Cell phone: (_____)-_____-_____

UNLV E-Mail address: _____

Personal E-mail address:_____(for non-admitted students)

I hereby authorize my Healthcare Provider to release information requested in this document and further authorize DRC to communicate with the named individual or agency identified below to obtain clarification as needed to determine my eligibility for disability services at UNLV. This authorization is valid for 6 months.

Student
Signature _____ Date:_____

Parent Signature
(If student is under 18):_____Date: _____

## DIAGNOSTIC INFORMATION

**(Please Print Legibly or Type)**

## (Please Print Legibly or Type)

*Please provide responses to the following items by typing or writing in a legible fashion.*

_____

_____

_____

3. List of current medications, impact, and adverse side effects, if any.

4. Major Life Activities Assessment:

   Please check which of the following major life activities listed below are affected because of the impairment. Please indicate severity of limitations.

| Life Activity | 1. Negligible | 2- Moderate | 3- Substantial | Don't Know |
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7. Are there any situations or environmental conditions that might lead to an exacerbation of the condition?

_____

_____

_____

_____

**HEALTHCARE PROVIDER INFORMATION**

**Provider Signature:**_____**Date**: _____

**Provider Name (Print):** _____

**Title:**_____**License or Certification #:** _____

_____

_____

_____ _____ _____

_____ _____ _____