

Documentation Guidelines for Attention-Deficit/Hyperactivity Disorder

Please provide the following documentation:

- Documentation should be on letterhead, dated and signed by a qualified professional or evaluator, e.g. identifying credentials with license number(s).
- The substantial limitation in a major life activity should be described.
- Suggestions of accommodations being recommended (i.e. extra time, frequent breaks).
- Documentation should reflect data collected within the past three years at the time of request for services.
- A diagnosis consistent with the most recent DSM/ICD.
- Evidence of the following diagnostic criteria must be included in the documentation:
 - Some evidence, beyond simple self-report, of clinically significant inattention and/or hyperactivity-impulsivity symptoms prior to the age of 12 (in accordance with the DSM). Possible data sources for evidence of early symptoms include the following: parent/guardian report, medical reports, school records, and past evaluations.
 - Evidence of current clinically significant symptoms of either inattention and/or hyperactivity-impulsivity must be documented using appropriate standardized rating scales or norm-referenced measures of cognitive/executive functioning that provide comparisons to similarly aged individuals. However, in some cases, a detailed written statement from a qualified evaluator who has sufficient experience with the student and the student's symptom history may be sufficient.
 - Symptom presence must be assessed using student self-report and corroborated by an independent informant who has been able to observe the student's recent functioning.

- Current clinically significant symptoms must be present in at least two settings and interfere with social, academic, or occupational functioning.
- ☐ Verifiable evidence that symptoms are associated with significant functional impairment in the academic setting. Suggested sources for evidence of academic functional impairment include the results of a comprehensive psycho-educational evaluation, school records, and/or a comprehensive clinical interview that is described in a written statement by the evaluator.