



Accessibility,  
Counselling and  
Student Development

## Medical Documentation for Accessibility Services

### Accessibility, Counselling and Student Development

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#### ***Purpose of this form***

***Accessibility Services requires documentation from a licensed health care professional, who is qualified to communicate a diagnosis, and has in-depth knowledge of a student's condition, in order to arrange academic accommodation and/or related services. Documentation should be as complete as possible in order to facilitate Accessibility Services' assessment of a student's request for services.***

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#### ***To be completed by student:***

**Student Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Month/Day/Year)

**Student Number:** \_\_\_\_\_

I authorize the professional named below to disclose to Accessibility Services information on this form and additional or clarifying information that is necessary for provision of disability services at King's University College. I also authorize Accessibility Services to communicate with this professional in order to obtain information that is relevant to provision of Accessibility Services.

**Date:** \_\_\_\_\_

**Student Signature:** \_\_\_\_\_

Student's informed authorization for disclosure of information is obtained in accordance with the following sections of the *Freedom of Information and Protection of Privacy Act*. Sections 41.(1)(a), 41.(1)(b), and 41.(1)(c) allowing for the *use* of personal information and sections 42.(1)(b), s.42(1)(c), and s.42(1)(d) allowing for the *disclosure* of personal information.

Student Name: \_\_\_\_\_

Student Number: \_\_\_\_\_

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**To be completed by licensed health care professional:**

**Name (please print):**

\_\_\_\_\_

**Registration Number:**

\_\_\_\_\_

**Address of Professional:**

\_\_\_\_\_

**Telephone #:**

\_\_\_\_\_

\_\_\_\_\_

**Fax #:**

\_\_\_\_\_

**Profession:**

Family Physician     Pediatrician     Other \_\_\_\_\_

**Signature:**

\_\_\_\_\_

**Date:**

\_\_\_\_\_

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**Diagnostic Statement (\*\*requested, but not required)**

Please provide a clear diagnostic statement or indicate that the student’s difficulties do not meet criteria for a diagnosis. If more than one condition is present that may affect academic progress, please specify all relevant conditions. Failure to provide a diagnosis does not preclude the student from receiving supports. Please complete the remainder of the form, even if a diagnosis is not stated.

**Diagnosis**

\_\_\_\_\_

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

GAF Score: \_\_\_\_\_

Student Name: \_\_\_\_\_

Student Number: \_\_\_\_\_

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Date of the condition’s onset: \_\_\_\_\_

Date of last clinical assessment: \_\_\_\_\_

How long have you been treating this student? \_\_\_\_\_

Has the student undergone a psychological, neuropsychological, or psycho-educational assessment?

Yes

No

Has the student completed any standardized or non-standardized rating scale?  Yes  No

If yes, please specify the scales used:

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### **Statement of Permanent Disability**

The designation of permanent disability has legal implications and is used in determining a student’s eligibility for Government grants and loans. Please refer to the following definition of permanent disability when answering the question below it.

Permanent disability is defined as: *a **functional limitation** due to a disorder that restricts a person’s ability to perform daily activities necessary to participate in post-secondary studies and is expected to remain with the person for the person’s expected life.*

In your professional opinion, does the student’s condition meet the criteria for a permanent disability as defined above?

Yes

No

***Please check the appropriate description(s) as they apply to this student’s condition.  
(Check all that apply)***

- Not a disabling condition in the current academic setting.
- Temporary disability: anticipated duration from \_\_\_\_\_ to \_\_\_\_\_.
- Permanent disability with ongoing chronic symptoms.
- Permanent disability with episodic symptoms. Is the student currently experiencing symptoms? \_\_\_\_\_
- Updated documentation regarding disability status should be reassessed every \_\_\_\_\_ because of the changing nature of the illness.
- This student is in stable condition and able to cope with typical academic stressors.

Student Name:

Student Number:

**Medication Information (optional)**

Please list medications that the student is taking.

Brand or Generic Name	Dosage and Frequency	Adverse effects <u>currently experienced</u> that may affect academic functioning

Does the medication have side effects that will affect the student negatively in an academic setting? Please describe:

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When is the student’s condition likely to have a negative effect on their academic functioning? (Check all that apply)

- Morning       Afternoon       Evening       N/A

If possible, please estimate how often the effects of the student’s disability may necessitate his or her absence from classes:  < 1 day per month       2 – 5 days per month       >5 days per month

Is it your opinion that the student will be able to meet the demands of a full course load (15 – 25 hours of lectures, labs, and/or tutorial meetings per week, plus 25 – 30 hours of study time per week)?  Yes     No

If your answer is no, please estimate the maximum amount of time that the student would be able to spend in these activities: approximately \_\_\_\_\_ hours per week.

Will you be monitoring this student on a regular basis while he/she is attending university?     Yes     No

Student Name: \_\_\_\_\_

Student Number: \_\_\_\_\_

**Functional Implications**

Please check abilities and activities that are affected by the student’s *current symptoms*.

Abilities & Activities	No Impact	Mild Impact	Moderate Impact	Severe Impact	Don’t Know
<b>To what degree does the disability directly affect the following physical and sensory capacities?</b>					
Hearing/Listening					
Speaking/Responding <ul style="list-style-type: none"> <li>• Oral presentations</li> <li>• Class participation</li> </ul>					
Vision					
Reading					
Mobility					
Dexterity					
Handwriting					
Typing					
Note taking					
<b>To what degree does the disability directly affect the following cognitive abilities?</b>					
Working memory					
Long-term memory					
Speed of information processing					
Executive Functioning <ul style="list-style-type: none"> <li>• Organizing</li> <li>• Time management</li> <li>• Problem solving</li> </ul>					
Concentration <ul style="list-style-type: none"> <li>• Manage distractions</li> <li>• Attention</li> </ul>					
Communication					
<b>To what degree is the disability associated with any of the following symptoms?</b>					
Pain					
Fatigue					
Poor Concentration					
Activities of Daily Living					
Environmental Concerns <ul style="list-style-type: none"> <li>• Space/Location</li> <li>• Lighting</li> </ul>					

Student Name:

Student Number:

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**Does the disability affect the student’s tolerance for:**

- Sitting for less than 50 minutes
- Sitting for more than 50 minutes
- Standing for more than 15 minutes
- Walking (cannot walk more than \_\_\_\_\_ meters at a time)
- Utilizing stairs
- Lifting/Carrying

Are there situations or activities that may worsen this student’s condition (such as writing two exams within a 24hr period)?

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In what areas of functioning would you recommend that the student receive academic support? Please elaborate and indicate what type of support(s):

- Assistive technology/devices
- Classroom accommodations
- Exam accommodations
- Learning skills
- A combination of the above

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***Additional Information:***

***Thank you for taking the time to complete this form. Feel free to include additional information, on your official letterhead, including copies of other applicable reports.***