

**Medical Report for Academic Accommodations and Services
Accessible Learning Services**

The information reported on this form will help Accessible Learning Services determine eligibility for academic accommodations and support services at Humber College/University of Guelph-Humber.

Information collected via this form is confidential.

TO ENSURE RECORD ACCURACY, PLEASE PRINT CLEARLY**TO BE COMPLETED BY THE STUDENT:**

Name: _____ Student # _____ Date of Birth: _____
(First) (Last) Day / Month / Year

Address: _____
(Street and Number) (City, Province) (Postal Code)

Phone: _____ - _____ - _____ Email: _____

STUDENT CONSENT TO RELEASE OF INFORMATION

I, _____, hereby authorize my health care practitioner to provide the following information to Accessible Learning Services. I understand that it is my responsibility to pay for the cost of this documentation, if required.

Student Signature

Date

**TO BE COMPLETED BY STUDENT AND REGULATED HEALTH PROFESSIONAL
OPTIONAL STUDENT CONSENT TO DISCLOSURE OF DISABILITY TYPE**

Please note that in accordance with the *Ontario Human Rights Code*, disclosure of a specific diagnosis is **NOT** required to access academic accommodations. However, disclosure of a diagnosis or disability type may help ALS better understand a student's needs.

→ **To be completed by the Regulated Health Professional:**

Disability type:

- | | |
|---|---|
| <input type="checkbox"/> Mobility Impairment | <input type="checkbox"/> Deaf, Deafened, Hard of Hearing |
| <input type="checkbox"/> Visual Impairment | <input type="checkbox"/> Mental Health Disability |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Attention Deficit Disorder (ADD) / Attention Deficit Hyperactivity Disorder (ADHD) |
| <input type="checkbox"/> Medical Disability | <input type="checkbox"/> Student chooses not to disclose disability type to ALS |
| <input type="checkbox"/> Acquired Brain Injury | <input type="checkbox"/> Other (specify) : |

TO BE COMPLETED BY THE REGULATED HEALTH PROFESSIONAL

The following criteria must be met when determining disability:

1. The student experiences functional limitation(s)
2. The functional limitation(s) impairs the student's academic functioning at the post-secondary level

▪ In your opinion, does this person have a disability?

- Yes No Unsure

▪ If yes, is the disability:

- Permanent**
 Temporary: Anticipated date of recovery Day _____ Month _____ Year _____
 In process of being assessed

SKILLS AND ABILITIES - FUNCTIONAL IMPACT					
DEGREE OF IMPACT →	NONE	MILD	MODERATE	SEVERE	UNKNOWN
COGNITIVE					
Attention / concentration					
Long-term memory					
Short-term memory					
Executive functioning					
Information processing					
Time management					
Ability to manage distractions					
Judgement – anticipating the impact of one's behaviour on self and others					
PHYSICAL					
Attendance / absence from class					
Chronic pain					
Stamina (consider fatigue and lethargy)					
Mobility					
Gross motor					
Fine motor					
Ability to sit for a sustained period of time					
Ability to stand for a sustained period of time					
SENSORY					
Vision (best corrected)					
Hearing (best corrected)					
Speech					
Touch					
SOCIAL/EMOTIONAL					
Control emotions during routine academic interactions					
Work effectively in group work situations					
Ability to deliver class presentations					
Reading social cues					
Ability to manage academic stress					
OTHER - Please indicate any additional functional limitations including the (side) effects of medication. If more space is required, please attach.					

