Student Accessibility Services Medical Form

** This form is best read with Adobe Acrobat Reader or Natural Reader. **Please save the form as a PDF before completing the form.** **

This Medical Form, once completed by a health care practitioner, should be converted to a digital format, and uploaded by the student to our Registration Portal.

Please note: Students diagnosed with a Learning Disability or Learning Disorder are asked to provide a copy of the report from their most recent psychoeducational assessment. If you have such a diagnosis, you do not need to complete this form.

Students applying for the Ontario Student Assistance Program (OSAP) are advised to speak with a heath care practitioner about the completion of OSAP's Disability Verification Form (DVF). Visit the Forms page of the OSAP website to download the DVF.

Privacy & Confidentiality

Student Accessibility Services provides academic accommodation and support to students with disabilities in accordance with the Ontario *Human Rights Code* and York University's Senate Policy on Academic Accommodation for Students with Disabilities. This form is used and retained in accordance with the *Freedom of Information and the Protection of Privacy Act* (FIPPA) and York University's Policy on Access to Information and Protection of Privacy and Records and Information Management Policy.

How is this form used?

Academic accommodations are designed on an individual basis to provide equitable access to education, to remove barriers that effect the demonstration of knowledge and skills in the classroom/lab/practicum settings. Accommodations do not guarantee a specific level of academic achievement and they cannot undermine academic integrity: students must meet all the academic requirements and standards of their courses and program. A diagnosis alone does not automatically mean disability-related accommodation is needed. The information provided in this Medical Form is used by our office to:

1. Verify that the student has a disability.
2. Understand the impact of the student's disability on their academics.
3. Recommend reasonable and appropriate academic accommodations and supports and to establish eligibility for some funding (e.g. the Bursary for Student with Disabilities).

Who should complete this form?

This form should be completed by a regulated health practitioner who is licensed to diagnose the condition. The provision of supplementary documentation from other service providers (health or education) is welcome. Students can include supplementary documentation as part of registration with our office. Supplementary documentation is not intended to replace this Medical Form.

Interim Accommodations

Interim accommodations can sometimes be put in place for students who are in the process of being assessed and/or monitored to determine a diagnosis. Health care practitioners can indicate that the student is in the process of being assessed (section III of this Form) and provide all information possible relating to functional limitations/restrictions (section IV of this Form).

Support on Compassionate Grounds

Support is available at York for students who need support for non-disability related reasons (i.e. students who are experiencing high levels of stress, test anxiety as well as students experiencing a personal crisis, such as the loss of a loved one). We can advise students on how to access consideration on compassionate grounds and/or personal counselling support. For more information, visit our Supports & Services page.

**** Please save the form as a PDF before completing the form. ****

Section I. Student Information (to be completed by student):

Name (Please Print) _____ Date of Birth (month / day / year) _____

York Student Number _____ Email Address _____

Disclosing a diagnosis is a choice and is not required to receive academic accommodations through our office. If you chose to disclose your diagnosis, this information will be used to determine appropriate on and off campus referrals and resources.

Consent to the disclosure of a mental health diagnosis:

- ◯ I consent to my diagnosis being identified on this Form and provided to Student Accessibility Services at York University.
- ◯ I do not consent to the disclosure of my diagnosis.

Section II. Statement of Disability (to be completed by health care practitioner):

1. Indicate the appropriate statement for this student in the current academic setting:

- ☐ This student has a long-term disability with ongoing symptoms (chronic or episodic) that will impact the student throughout their academic career and are expected to be lifelong.
- ☐ This student has a short-term, temporary disability. Accommodations to be provided from:

Start date (month / day / year) _____ End date (month / day / year) _____

- ☐ This student is in the process of being monitored and assessed to determine a diagnosis. This assessment is likely to be completed by:

Completion date (month / day /year) _____

[Updated documentation will be needed to extend accommodations beyond this date]

- ☐ This student has been referred to a specialist for an assessment:

Date of referral (month / day /year) _____

2. Identify the nature of the student's primary diagnosis. If applicable, indicate nature of any/all disabilities that co-occur with the primary diagnosis.
   - If a student is being assessed, indicate the nature of the student's primary diagnosis (or diagnosis being explored).

Nature of Disability	**Primary diagnosis (check only one)**	**Secondary diagnosis (check all that apply)**
Acquired brain injury, concussion, or head injury	◯	☐
Medical (chronic or acute)	◯	☐
Neurodevelopmental Disorder [for example: Autism Spectrum or Attention Deficit/Hyperactivity Disorder]	◯	☐
Deaf/deafened/hard of hearing	◯	☐
Blind/low vision	◯	☐
Injury or recovery from surgery	◯	☐
Mobility or dexterity	◯	☐
Mental health	◯	☐
Other (please specify):	◯	☐

3. Diagnosis*:

*__Please note__: a student's diagnosis is **not required** to receive accommodations and supports from Student Accessibility Services. Please share this information **only** if the student has consented to their diagnosis being shared with our office (see Section I).

4. To what extent is the student's diagnosis based on the following sources of information?

Source	**Primary source (check only one)**	**Limited source (check all that apply)**	**Not used**
Student's self-report	◯	☐	☐
Clinical observation	◯	☐	☐
Standardized assessment techniques	◯	☐	☐
Information from parents, teachers, etc.	◯	☐	☐
Other (please specify):	◯	☐	☐

Section III. Support/Treatment History (to be completed by health care practitioner):

1. How long have you provided service(s) to this student?

☐ Less than 2 years ☐ More than 2 years ☐ First visit/ walk-in

2. Will you continue to provide service(s) to this student while they attend York University?

☐ Yes ☐ No ☐ Unknown

3. Does the student's condition and/or treatment significantly affect functioning at certain times of the day?

☐ Yes ☐ No

If **Yes**, then please indicate when:

☐ Morning ☐ Afternoon ☐ Evening

4. Does the student have regularly scheduled medical appointments or treatments that would require them to miss academic commitments?

☐ Yes ☐ No

If **Yes**, then please indicate frequency:

5. Would you recommend to the student that they consider a referral to a psychologist for further assessment?

☐ Yes ☐ No

Please note: depending on circumstances, there could be a cost to the student. We can explore funding options with them.

6. Does this student have a condition such that the university may need to respond in an emergency situation if symptoms of the condition appear while the student is on campus/ during fieldwork/practicum placement (e.g. seizure disorder, severe allergic reaction)

☐ Yes ☐ No

If **Yes**, please elaborate:

Section IV. Support/Treatment History (to be completed by health care practitioner):

How is this student likely to be affected in a university learning environment? Please indicate which of the following are impacted by the student's disability, the level of impact and recommendations to manage the impact.

Part A: Academic Tasks

	Impact of disability on task or skill					
Task or skill	**None**	**Mild**	**Moderate**	**Severe**	**Unknown**	**Impact on academic functioning. Recommendations to manage impact.**
[EXAMPLE ONLY] Note taking			✓			*Student may be distracted or overwhelmed during class and miss parts of what the instructor says.*
Note taking	○	○	○	○	○	
Participation in classroom discussions/ group work	○	○	○	○	○	
Delivery of oral presentations	○	○	○	○	○	
Attendance	○	○	○	○	○	
Meeting course deadlines (essays, assignments)	○	○	○	○	○	
Managing emotions during academic evaluations	○	○	○	○	○	

Part B: Cognitive and/or Behavioural

	Impact of disability on symptom or task					
Symptom or task	**None**	**Mild**	**Moderate**	**Severe**	**Unknown**	**Impact on academic functioning. Recommendations to manage impact.**
[EXAMPLE ONLY] Focus and concentration			✓			*Student loses focus after 15 minutes of sustained attention. Should have quiet space to write exams, extended time to write exams, note taking supports. Reduced course load.*
Focus and concentration	○	○	○	○	○	
Cognitive processing of information	○	○	○	○	○	
Long-term memory (recall/ retrieve stored information)	○	○	○	○	○	
Executive functioning (multi-tasking, prioritizing tasks, time management)	○	○	○	○	○	
Understanding common social cues (e.g.facial expressions, body language)	○	○	○	○	○	
Managing internal distractions	○	○	○	○	○	
Managing external distractions	○	○	○	○	○	
Social interactions	○	○	○	○	○	
Emotional regulation when stressed	○	○	○	○	○	
Other (please specify):	○	○	○	○	○	

Part C: Physical, Mobility & Movement

	Impact of disability on symptom or task					
Symptom or task	**None**	**Mild**	**Moderate**	**Severe**	**Unknown**	**Impact on academic functioning. Recommendations to manage impact.**
[EXAMPLE ONLY] Sleep disturbance			✓			*Student loses focus after 15 minutes of sustained attention. Should have quiet space to write exams, extended time to write exams, note taking supports. Reduced course load.*
Sleep disturbance	○	○	○	○	○	
Fatigue	○	○	○	○	○	
Pain	○	○	○	○	○	
Speech	○	○	○	○	○	
Lifting over 5 lbs.	○	○	○	○	○	
Reaching above shoulders	○	○	○	○	○	
Bending	○	○	○	○	○	
Fine motor / manual dexterity	○	○	○	○	○	
Climbing stairs	○	○	○	○	○	
Walking	○	○	○	○	○	
Sitting for sustained periods of time*	○	○	○	○	○	
Standing for sustained periods of time	○	○	○	○	○	
Other (please specify):	○	○	○	○	○	

*Student Accessibility Services will provide alternate seating with the following features: moderate back support, cushioned back and seat arms. Please indicate whether these features meet the student's essential needs to access a classroom environment.

☐ Yes ☐ No† ☐ Unable to assess†

†Please note that if the above chair features are not adequate for the student to access the classroom environment, and specialized ergonomic features are needed, an ergonomic assessment is required for the student to access the specialized seating. The ergonomic assessment should include a list of the chair features that are needed as well as a rationale for each of the requirements that are listed in the assessment. Ergonomic assessments may be completed by an Occupational Therapist, certified professional ergonomists, other qualified regulated professionals.

Assessments and specialized orders may take several months to complete.

If your patient has recently completed an ergonomic assessment or has relevant supporting medical documentation, please attach it.

Part D: Vision

Vision/ Impact	No Impact	Mild	Moderate	Severe	Legally Blind	Adaptive technology and/or aids used? Please indicate if symptoms are stable or progressive.
Left Eye						
Right Eye						

Part E: Hearing

Hearing/ Impact	None	Mild	Moderate	Severe	Deaf	Adaptive technology and/or aids used? Please indicate if symptoms are stable or progressive.
Left Ear						
Right Ear						

Based on the information you have provided on this Form, do you have any additional recommendations for academic accommodations and/or support(s) for participation in post-secondary academics (for example: personal counselling, reduced course load, note taking supports)? Please provide rationale(s).

Health Care Practitioner Information:

Name (please print):

Professional Designation:

Registration Number:

Date:

Signature:

Office Address and Phone Number:

Office Stamp or Business Card
(please affix a business card only if your office has no stamp)

Student Consent:

I give consent for authorized persons within Student Accessibility Services to contact the health practitioner listed on this form to discuss the information regarding my disability and accommodation needs outlined on this form.

Student's signature

Signature date (month / day / year)

Please note the following:

- Additional documentation may be requested as part of accommodation planning.
- Reminder: This document, once completed by a health care practitioner, should be converted or saved to a digital format (PDF). Please visit our New Students page for more information on how to submit this form via our secure portal. **Please do not email this form as email is not secure.**