Queen's Student Accessibility Services
Queen's University
Côté Sharp Wellness Centre, Mitchell Hall
69 Union Street | Kingston, ON | K7L 3N6
613-533-2506
https://www.queensu.ca/studentwellness/accessibility-services/

Verification
ATTENTION/ LEARNING/ NEURODIVERSITY

PART A – *To be completed by student*

STUDENT INFORMATION

Last Name: ________________________ Preferred/Given Name: _______________________

Date of Birth: ______________________ Student Number: _____________________________

Queen's Net ID: ____________________ Phone Number: ______________________________

DISCLOSURE & CONFIDENTIALITY

- Medical diagnosis is not required to receive accommodations.
- To recommend appropriate accommodations QSAS uses information about how your medical diagnosis might impact you at university.
- If you consent to share medical diagnosis, QSAS will maintain strict confidentiality. Information about medical diagnosis will not be shared without your express and written consent.
- All other information on this form will be kept strictly confidential, even if consent to share medical diagnosis is not provided.

Do you consent to your medical diagnosis being identified on this form and communicated to Queen's Student Accessibility Services (QSAS)?

YES ☐ **NO** ☐

RELEASE OF INFORMATION

I hereby authorize my Health Care Professional (HCP), who is completing and signing this form, to share my functional impacts with Queen's Student Accessibility Services (QSAS).

Student Signature: _________________________________ Date: ____________________

Personal information is collected under the authority of the *Queen's University Royal Charter, 1841,* as amended, and will be used to provide disability-related services and accommodations for studies at university. Questions regarding the collection or use of this personal information should be directed to Manager, QSAS, 69 Union Street, Kingston, ON, K7L 3N6, (613) 533-2506, accessibility.services@queensu.ca

PART B – *To be completed by Health Care Provider*

VERIFICATION OF IMPACT

If student has consented above to disclose their medical diagnosis, please provide a diagnostic statement below.

MEDICAL INFORMATION – FUNCTIONAL IMPACTS

Level of Severity	Mild	☐	Moderate	☐	Severe	☐
Is functioning restricted to certain times of day?	Morning	☐	Afternoon	☐	Evening	☐
Is student currently taking medication?	YES	☐	NO	☐		

If yes, please specify any side effects that may impact the student's academic functioning?

RESTRICTIONS & LIMITATIONS

Symptoms/Restrictions	Mild to Moderate	Serious to Severe	Comments
PHYSICAL			
Sensitivity to Tactile or Olfactory Stimuli			
Sensitivity to Visual Stimuli			
Sensitivity to Auditory Stimuli			
THINKING			
Difficulty Concentrating			
Difficulty Recalling Information			
Difficulty Processing Information			
Difficulty Organizing/Planning			
Difficulty with Divided Attention			
Difficulty Managing Internal Distractions			
Difficulty Managing External Distractions			
Difficulty with Sustained Attention/Focus			
SOCIO-EMOTIONAL			
Difficulty Interacting with Others			
Difficulty Making Decisions			
Problems with Procrastination			
Poor Time Management			

ACADEMIC IMPACTS

	Mild to Moderate	Serious to Severe	Comment
Attending Class			
Taking Notes			
Reading			
Writing Assignments			
Completing Exams			
Delivering Presentations			
Meeting Assignment Deadlines			
Participating in Group Activity			
Other			

COURSE LOAD

Is student's condition sufficiently stable at this time to sustain participation in regular university academic activities? YES ☐ NO ☐

Would you recommend a Reduced Course Load for this student? YES ☐ NO ☐

Additional Information on course load (if required)

HEALTH CARE PROFESSIONAL INFORMATION

Name (please print)	
Signature	
Date (DD, MM, YR)	
Specialty	
Registration/License No.	
Facility Name and Address (Use Official Stamp if Available	
Phone	
Email	