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
MEDICAL/BRAIN INJURY

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.

DURATION

☐ **Permanent:** *Anticipated to impact student throughout academic career at Queen's.*

☐ **Permanent (Episodic):** *Anticipated to impact student through academic career with periods of good health.*

☐ **Temporary:** *Accommodations will be provided until the end of the following academic term*, unless alternate duration specified below.*

Alternate duration _____/_____ (MM, YR)

☐ **Provisional:** *Monitoring/Assessment under way*

Anticipated assessment completion date _____/_____/_____ (DD, MM, YR)

*Accommodations provided **Spring/Summer** expire **Dec. 31**; **Fall** expire **Apr. 30**; **Winter** expire **Aug. 31**

MEDICAL INFORMATION – FUNCTIONAL IMPACTS

Level of Severity	Mild	☐	Moderate ☐	Severe	☐
Date of Onset			____/____/____/	(DD, MM, YR)	
Is student currently at risk for self-harm or harm to others?	YES	☐	NO ☐		
If yes, has a safety plan been established?	YES	☐	NO ☐		
Is functioning restricted to certain times of day?	MORN.	☐	AFTER. ☐	EVEN.	☐
Is student currently taking medication?	YES	☐	NO ☐		

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

AIDS & SUPPORTS USED BY STUDENT

Blood Pressure Monitor	☐	Glucometer	☐
Epi-Pen	☐	Inhaler	☐
Other _____		Other _____	

CONCUSSION INFORMATION – only:

Level of Severity	Mild ☐	Moderate ☐	Severe ☐	
Date of Injury	_____/	_____/	_____/	(DD/MM/YR)
Date of Recent Assessment	_____/	_____/	_____/	(DD/MM/YR)
Date of Next Assessment	_____/	_____/	_____/	(DD/MM/YR)
Previous concussions?	YES ☐	NO ☐		
How many and approx. when?	NO. _____	WHEN _____		

RESTRICTIONS & LIMITATIONS

Symptoms/Restrictions	Mild to Moderate	Serious to Severe	Comments
Difficulty with…			
…performing tasks of daily living			
…managing pain			
…physical tolerance			
…walking short distances			
…prolonged standing [_____minutes]			
…prolonged sitting [_____minutes]			
…climbing stairs			
…lifting weight [_____lbs]			
…stress management			
…concentration			
…attention			
Nausea			
Sensitivity to light			
Sensitivity to noise			
Eye Strain/Fatigue after ____ minutes			
Restricted Ability to View Screen			
Restricted Ability to Read Print (paper)			
Visual/Perceptual Problems			
Vomiting			
Other			

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	