NIPISSING
UNIVERSITY
STUDENT DEVELOPMENT AND SERVICES

STUDENT INFORMED CONSENT FOR PHYSICAL, SENSORY, AND MEDICAL DISABILITIES

This section to be completed by the student PRIOR TO asking a health care professional to complete the following Medical Documentation Form. Attach this form to Medical Documentation Form and provide both to health care practitioner.

Please Print:

Student's Last Name: _____
Student's First Name: _____
Date of Birth (mm/dd/yyyy): _____
Student Number: _____
Email Address: _____

Consistent with the Ontario Human Rights Commission, Nipissing University does not require you to disclose your diagnosis in order to register with Student Accessibility Services (SAS) and to receive academic accommodation. Although not required, a diagnosis is used by a relevantly trained disability service professional in Student Accessibility Services to infer and anticipate barriers and accommodation needs in an academic setting, where relevant information is not otherwise available.

Providing your diagnosis may be required to establish eligibility for certain federally or provincially funded bursaries and grants and privately-funded external scholarships and financial awards. This form can be used to establish eligibility for such financial assistance, provided you have consented to the disclosure of your diagnosis.

If you decide to disclose your diagnosis, please note that this information will kept strictly confidential. Student Accessibility Services will not share this information with anyone, including your instructors, without your explicit and written consent.

If you choose to consent to the disclosure of your diagnosis, you must check the box below. Your consent will allow your health care practitioner to complete the relevant section of the form.

☐ I consent to disclose the diagnosis of my disability.

_____ _____
Signature of Student Date

_____
Please Print Name

Student Accessibility Services - Nipissing University 100 College Drive, Box 5002, North Bay, ON, Canada P1B 8L7
Tel: 705.474.3450 ext. 4362 | Fax: 705.495.2850 | TTY: 877.688.5507

MEDICAL DOCUMENTATION FORM FOR PHYSICAL, SENSORY, and MEDICAL DISABILITIES

Student Name: _____ Date of Birth: _____/_____/_____ (mm/dd/yyyy)

Dear Healthcare Practitioner,

This student is requesting disability-related supports and accommodations while studying at Nipissing University. The student is required to provide the University with documentation that is:

A. Completed by a **regulated healthcare professional who has knowledge of the patient's history and is licensed to diagnose the disability.**

B. All sections of the form must be completed fully and objectively to ensure **accurate assessment of the student's disability-related needs**, which may have significant implications on access to support services and academic accommodations in university, or entitlement to a range of benefits including government funding.

C. Careful consideration should be given to the **statement of disability and relevant functional limitations**. Please note, a diagnosis is requested but not required for students to receive academic accommodations; however, if diagnosis is not provided, functional limitations must be fully described and additional information may be requested in order to determine appropriate accommodation and support. **We rely on your detailed knowledge of this student's disability and functional limitations to assist in the planning of appropriate accommodations through Student Accessibility Services.**

Diagnostic Statement (see requirement C above)
State your DSM diagnosis for this student *(to be provided with student's consent)*

☐ **Acquired Brain Injury/Concussion** Dx Onset: _____

☐ **Mental Health** *(may require additional documentation***)** Dx:_____

☐ **Medical** Dx: _____

☐ **Hearing**

	Left Ear	Right Ear
Hearing loss (specify type and severity)		
Tinnitus		
Other (please specify)		
Does the patient's hearing fluctuate? Please describe:		

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☐ **Vision**

Visual Acuity	Visual Acuity- Best Corrected	Visual Field	Visual Field – Best Corrected
Other comments on diagnosis (e.g., night vision, depth perception, colour perception, etc.):			

☐ **Other** Dx: _____

☐ **I am in the process of monitoring and assessing the student's health condition to determine a diagnosis and this assessment is likely to be completed by** _____.

Statement of Disability (see requirements B & C above):

In my professional opinion, I can confirm the student has a formally diagnosed disability, as follows:

☐ **Permanent disability** with ongoing symptoms:

□ Chronic (ongoing symptoms for the duration of natural life)

□ Acute (recurring episodes with relatively symptom-free periods of remission)

☐ **Temporary disability** with anticipated duration of:_____

☐ This student must be reassessed every _____ due to the changing nature of the illness, or requires follow up for monitoring.

Restrictions and Limitations

As this certificate covers the impact of various disabilities, there are questions that may not be relevant to your patient. Check only the areas that apply.

Where noted, please indicate the severity of the disability and the **functional impact in an academic environment.**
Mild: The student should be able to cope with minimal support.
Moderate: The student requires some degree of academic accommodations, as symptoms are more prominent.
Severe: The student has a high degree of impairment, with significant academic accommodations required, as symptoms impact and interferes with academic functioning.

PHYSICAL	
Pain ☐ Chronic ☐ Episodic	☐ Mild ☐ Moderate ☐ Severe ☐ Impact on academic functioning:

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Headaches/Migraines ☐ Headaches ☐ Migraines Frequency: Triggers:	☐ No impact ☐ Mild ☐ Moderate ☐ Severe ☐ Impact on academic functioning:
Sleep Cycles and Energy ☐ Fatigue ☐ Fluctuating Energy ☐ Sleep disorder or difficulties	☐ No impact ☐ Mild ☐ Moderate ☐ Severe ☐ Impact on academic functioning:
Bowel and Urinary ☐ Chronic ☐ Episodic	☐ No impact ☐ Mild ☐ Moderate ☐ Severe ☐ Impact on academic functioning:
Stamina ☐ Reduced stamina	☐ No impact ☐ Mild ☐ Moderate ☐ Severe ☐ Breaks required (specify frequency) :
Standing (e.g. sustained standing in laboratory) ☐ Activity as tolerated	☐ No prolonged standing (specify minutes):
Sitting for sustained period of time (e.g. in lecture or exam) ☐ Activity as tolerated	☐ No prolonged sitting (specify minutes):
Lifting/Carrying/Reaching ☐ Activity as tolerated	☐ Advised not to carry more than _____ lbs. ☐ Limited reaching, pulling, pushing ☐ Limited range of motion (please specify): ☐ Other (please specify):
Grasping/gripping	☐ Minimize repetitive use ☐ Limited dexterity ☐ Limited handwriting ability ☐ Other (please specify):

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Ambulation ☐ Activity as tolerated	☐ Restrictions (please specify):
COGNITIVE SKILLS/ABILITIES	
Cognitive fatigue	☐ Rest is required due to acquired brain injury (including concussion) ☐ Student advised to withdraw from school activities until effects of injury subside **Date recommended to return to studies:**
Memory Deficit ☐ Short term ☐ Long term	☐ No impact ☐ Mild ☐ Moderate ☐ Severe
Concentration	☐ No impact ☐ Mild ☐ Moderate ☐ Severe
Information Processing	☐ No impact ☐ Mild ☐ Moderate ☐ Severe
Time Management and Organization	☐ No impact ☐ Mild ☐ Moderate ☐ Severe
Note Taking	☐ No impact ☐ Mild ☐ Moderate ☐ Severe
STRESS MANAGEMENT	
Difficulty with high pressure situations (e.g. managing multiple deadlines, exams, heavy workload)	☐ No impact ☐ Mild ☐ Moderate ☐ Severe
COMMUNICATION	
Deficits in oral communication	☐ No impact ☐ Mild ☐ Moderate ☐ Severe

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Medication

If the student has been prescribed medication for this condition, when is the medication likely to affect academic functioning negatively? (Check all that apply)

☐Morning ☐Afternoon ☐Evening ☐N/A

1) Based on the functional limitations, can the student sustain a full time course load (4 or 5 courses per term)?

Yes ☐ No, a reduced course load is recommended ☐

2) Do you consider the student to be in stable condition and capable of sustaining normal academic stress with appropriate supports, including practicum/fieldwork (if applicable)?

Yes ☐ No ☐ Please explain:_____

3) Please provide any additional information that may assist us in determining appropriate accommodations and support services.

CERTIFICATE OF ASSESSING PROFESSIONAL

Please specify type of practitioner:

- ☐ Family Physician
- ☐ Audiologist
- ☐ Optometrist
- ☐ Ophthalmologist
- ☐ Neurologist
- ☐ Gastroenterologist
- ☐ Other (please specify): _____

I hereby certify that I provided health care services to, _____, a student at Nipissing University, on [date(s)], _____. I am providing the above information for use by the University in assessing what academic accommodation, if any, should be given to this student. I understand that I may be contacted by the University to verify this information, but will not be requested to provide further information without the consent of the student.

Name (please print):_____ Registration Number:_____

Signature:_____ Date:_____

Name/Address/Phone Number:
Please use office stamp or attach business card