Accessibility Services
100 College Blvd
Box 5005
Red Deer, Alberta
CANADA T4N 5H5
Telephone: 403.357.3629
Fax: 403.346.8500
Website: www.rdc.ab.ca

MEDICAL INFORMATION QUESTIONNAIRE

ACCESSIBILITY SERVICES

The personal information that you provide on this form is being collected under the authority of the ***Post-Secondary Learning Act***, SA 2003, c P-19.5 and the ***Freedom of Information and Protection of Privacy Act***, RSA 2000, c F-25. This information will be used by Accessibility Services to provide the student with appropriate accommodations and services, and may be used for disability related Grant Funding purposes. The information will be protected in compliance with the provisions of the ***Freedom of Information and Protection of Privacy Act***. The information will be retained in accordance with Red Deer College's *Information Access and Protection of Privacy Policy,* after which it will be destroyed in a secure manner. If you have any questions about the collection and use of this personal information, please contact the Accessibility Coordinator at Red Deer College, Box 5005, Red Deer, Alberta, T4N 5H5, Telephone: 403.357.3629.

DOCUMENTATION OF DISABILITY OR MEDICAL CONDITION

Accessibility Services at Red Deer College requires that students, who seek academic accommodations due to a disabling condition, provide appropriate documentation of their disability. This documentation may also be used to help the student secure grants from Student Aid. All information received will be kept strictly confidential and will only be used to determine appropriate support services and will potentially aid in receiving grant funding. It will not affect an applicant's chances of being accepted in to the program of their choice.

Please be aware that the student is responsible for any costs incurred for the collection of the documentation.

TO BE COMPLETED BY THE STUDENT – PLEASE PRINT CLEARLY

STUDENT INFORMATION

LAST NAME	FIRST NAME	DATE
STUDENT ID NUMBER	DATE OF BIRTH (DD/MM/YYYY)	PHONE
☐ I authorize the below named professional to provide the information contained in this report to Accessibility Services at Red Deer College and if required, provide additional information for consideration of my request for academic accommodations and disability-related services. I am aware that I am responsible for any costs incurred for assessments or medical visits. I also authorize Accessibility Services to contact the health care professional to discuss the provision of accommodations.		
STUDENT SIGNATURE	WITNESS SIGNATURE	WITNESS NAME

TO BE COMPLETED BY A HEALTH CARE PROFESSIONAL – PLEASE PRINT CLEARLY

Please indicate the nature of the medical information provided	☐ MEDICAL	☐ MENTAL HEALTH	☐ OTHER	
Is this person a regular patient of yours?	☐ YES	☐ NO		

Diagnosis and/or nature of the condition

For mental-health /ADHD, please include a DSM code (where relevant, e.g. 300.02) and attach supporting documents (e.g., relevant assessments, medical reports, etc.)

STATEMENT OF DISABILITY

Please check the appropriate statement(s) for this student in the current academic setting:

☐ This diagnosis is a **permanent disability** in the academic setting (please check all that apply):

- ☐ Functional limitation (chronic/episodic) that is caused by a physical or mental impairment
- ☐ Restricts the student's ability to perform the daily activities necessary to fully participate in studies
- ☐ Is expected to remain with the student for their expected natural life

☐ This diagnosis is a **temporary disability** in the academic setting: Anticipated duration from ___/___/___ to ___/___/___ (DD/MM/YYYY)

BRIEF DESCRIPTION OF FUNCTIONAL LIMITATIONS AND CONCURRENT CONDITIONS

While disclosure of the diagnosis is voluntary on the part of the student, please indicate the nature of the disability by providing a brief description of the limitations and concurrent conditions associated with the diagnosis in the categories below. There may be some instances where the diagnosis is required to establish eligibility for specific resources. Please provide a clear statement; avoid terms such as "suggests" or "is indicative of". Please note any multiple limitations or concurrent conditions. In relation to the aforementioned Statement of Disability, please note all applicable:

FUNCTIONAL LIMITATIONS:

IMPACTS ON ACADEMIC FUNCTIONING DUE TO DISABILITY AND/OR MEDICATIONS (PLEASE BE SPECIFIC)

Please provide specific detail on any **physical and/or cognitive** impacts of the disability that may affect **academic** functioning:

- ☐ Not Applicable
- ☐ Mobility
- ☐ Sight/Vision
- ☐ Hearing/Auditory
- ☐ Communication
- ☐ Information processing
- ☐ Executive functioning
- ☐ Stress management
- ☐ Energy Levels
- ☐ Reading and/or writing

Ability, over extended periods to:

- ☐ Take notes
- ☐ Remain seated or stationary
- ☐ Maintain focus & concentration
- ☐ Lifting/Carrying/Reaching
- ☐ Other

Please describe any further barriers that have an impact on academic functioning. Attach additional documentation if required

RESOURCES AND ACCOMMODATIONS RECOMMENDED

Please indicate your recommended resources and accommodations based on your assessment of the student, the identified disability and related barriers identified above. (Please check ☒ all that apply):

☐ Extended time for tests/exams (specify amount below)	☐ Exams to be completed in reduced-distraction environment
☐ The use of a recording device to record lectures	☐ Reducing the student's full-time program course load
☐ Priority seating in the classroom/exam room	☐ Allowing short breaks for physical repositioning; for washroom breaks
☐ Assistive software and/or technology – Please specify below	☐ Other - Please identify with comments

Comments/Specific/ Other Recommendations:

HEALTH CARE PROFESSIONAL INFORMATION

Name of professional (please PRINT):	Date:
Signature of professional:	Registration/Certificate #
Official Office Stamp or Address	Specialty: ☐ Family Physician ☐ Psychologist/ Psychiatrist ☐ Other: _____
Telephone:	Email:

SUMMARY OF DISABILITY DOCUMENTATION REQUIRED FOR STUDENT AID FUNDING

Type of Disability	Documentation Required by Student Aid
Deaf, Hard of Hearing	• Audiologist report, or • Letter from a physician with an explanation of the degree of hearing loss
Blind, Visually Impaired	• Specialist report, or • Letter from a physiciain with a description of the functional limitations
Learning Disability	• Physcho-educational report from a Psychologist, or • Neuro-psychological report
Speech	• Speech language pathologist report
Mobility/Agility Impairment	• Specialist report, or • Letter from a physician with an explanation of the nature of the mobility/agility impiarment (functional limitation)
ADD / ADHD	• Psychologist report, or • Neuro-psychological report, or • Letter from a psychiatrist, or • Letter from a physician with details about the diagnosis
Psychiatric or Pyschological	• Psychologist report with a DSM diagnosis, or • Letter from a psychiatrist with a DSM diagnosis, or • Letter from a physician with details about the diagnosis including the DSM
Autism, Asperger, Rett	• Psychologist report, or • Letter from a physician with details about the diagnosis
Brain Injury/Cognitive Impiarment	• Neuro-Psychological report, or • Brain injury/cognitive impairment report/assessment
Other Permanent Disability such as:	• Chronic Fatigue: a detailed letter from physician • Irlen Syndrome: assessment report from a certified Irlen Screener