Centre for Accessible Learning and Counselling Services

MEDICAL INFORMATION FORM

Centennial College Policy

Centennial College will make every reasonable effort to accommodate students who identify with having disabilities to meet the learning outcomes of the programs of instruction in which they are registered and to provide equal access to all programs and services.

Dear Health Care Professional,

You are receiving this form at the request of a Centennial College student who requires documentation from a qualified Health Care Professional in order to support academic accommodations and services with the Centre for Accessible Learning and Counselling Services (CALCS).

Our goal is to provide the necessary accommodations to equalize the opportunity for students to meet their essential course or program requirements while maintaining academic integrity. We are mandated by the Human Rights Commission's guidelines for Accommodating Persons with Disabilities, the Ontario Human Rights Code (OHRC) and Centennial College Policy SL100-05.

This form and the information contained herein is fundamental to the process of designing academic accommodations for your patient/client as a Centennial College student. All information will be kept strictly confidential and does not affect admission decisions. Academic accommodations may be necessary for the post-secondary academic activities of attending class, writing tests, completing assignments, doing presentations, etc., that require students to assume responsibility for their educational pursuits. We rely on your detailed knowledge of this student's disability, including the type of disability and a description of the current functional impact on their ability to meet essential course or program requirements. Disclosure of disability type may be required for some government financial aid programs for students with disabilities.

Please ensure that all information is accurate and complete. This form will be used, in collaboration with the student, to make decisions regarding accommodation. Please do not send information that you do not want shared with the student.

Additional Notes:

- **Learning Disability**: If available, please provide the most recent psycho-educational assessment.
- **Hearing Disability**: Please attach a copy of an audiology report for patients/clients who are deaf or experience hearing loss.
- **Mental Health/Psychiatric Disability**: Under the OHRC, it is not a requirement to provide a specific diagnosis or a disability type to access accommodations and supports from the CALCS. Should the student wish to disclose their diagnosis or disability type, an opportunity to provide consent to release this information is in the form.
- Only complete this form if there is no other supporting documentation for the student's disability OR you are providing information on an additional disability not already documented in a psycho-educational assessment or audiology report.

If you have any questions, please contact: 416-289-5000 Ext 53850 or calcs@centennialcollege.ca.

Thank you,

The Centre for Accessible Learning and Counselling Services

CENTENNIAL COLLEGE
Centre for Accessible Learning and Counselling Services

MEDICAL INFORMATION FORM

SECTION A: Student information *(To be completed by the student - PLEASE PRINT)*

Student Name: _____ **Student ID#:** _____

Phone: _____ **Email:** _____ **D.O.B.** _____
(month/ day/ year)

Campus (check one): ❒ Ashtonbee ❒ Downsview ❒ Morningside ❒ Progress ❒ Story Arts Centre

SECTION B: Student Consent for Release of Information
(To be completed by the student AND Health Care Professional)

In order to access accommodations and supports for your academic needs, you are required to consent to the sharing of the FUNCTION IMPACT section of this form. However, under the Ontario Human Rights Code, it is NOT a requirement to disclose or share DISABILITY TYPE or DIAGNOSIS to access academic accommodations and services from the CALCS.

Although optional, the disclosure of DISABILITY TYPE is required to access some government financial aid opportunities for students with disabilities. Furthermore, the CALCS recommends disclosure of DISABILITY TYPE, as it will aid the CALCS in best understanding how to assess and accommodate your needs. If you choose to disclose and share your DISABILITY TYPE, it will not be shared outside of the CALCS without your consent.

I, _____, authorize my Health Care Professional to provide the following information to the CALCS at Centennial College:

1. **FUNCTIONAL IMPACT:** By signing below, I authorize my Health Care Professional to disclose and share the functional impact of my disability to the CALCS at Centennial College, in order for me to access accommodations and supports for my academic needs.

   Student Signature: _____ **Date:** _____

2. **DISABILITY TYPE:** By signing below, I authorize my Health Care Professional to disclose and share my disability type to the CALCS at Centennial College, which will make me eligible for government financial aid opportunities.

   Student Signature: _____ **Date:** _____

   Disability Type – to be completed by Health Care Professional (check all that apply):

   ❒ Attention Deficit Hyperactivity Disorder (ADD/ADHD)
   ❒ Autism Spectrum Disorder
   ❒ Hearing
   ❒ Medical
   ❒ Mental Health
   ❒ Mobility
   ❒ Visual
   ❒ Other _____

3. **DIAGNOSIS**: By signing below, I authorize my Health Care Professional to disclose and share my diagnosis to the CALCS at Centennial College.

   Student Signature: _____ **Date:** _____

   Diagnosis – to be completed by Health Care Professional: _____

   Health Care Professional's Signature: _____ **Date:** _____

CENTENNIAL COLLEGE
Centre for Accessible Learning and Counselling Services

MEDICAL INFORMATION FORM

SECTION C – FUNCTIONAL IMPACT *(To be completed by Health Care Professional - PLEASE PRINT)*

The following criteria must be met when determining a disability:

1. The student experiences functional limitation(s) due to a health condition *and*
2. The functional limitation(s) impairs the student's academic functioning at the post-secondary level

Please select and complete ONE of the following:

- ❑ This student has a **permanent** disability with symptoms that are: ❒ continuous, or ❒ episodic
- ❑ This student has a **temporary** disability with symptoms that are: ❒ continuous, or ❒ episodic
  - Accommodations will be required until (date*): _____
- ❑ This student **is currently being assessed** and/or monitored to determine a diagnosis
  - Accommodations will be required until (date*): _____

*****_Updated documentation will be required after this date_

Length of time you have been seeing this patient/client: _____

If you indicated that the student has a permanent disability, do you recommend that the student take a reduced course load? ❒ Yes ❒ No

FUNCTIONAL IMPACT:
Current symptoms of condition and/or medication that may affect academic functioning – PLEASE INITIAL

Skills/Abilities	No Impact	Mild Impact	Moderate Impact	Severe Impact	Not sure	Comments/ Accommodation Recommendations
COGNITION						
Attention/Concentration						
Long-term Memory						
Short-term Memory						
Executive Functioning						
Information Processing						
Ability to manage distractions (filter out distracting visual and auditory stimuli)						
Judgement (anticipating the impact of one's behaviour on self and others)						
Ability to take notes during lectures						
Ability to meet assignment deadlines						
PHYSICAL						
Mobility						
Gross motor						
Fine motor						
Sitting for a sustained period of time						
Standing for a sustained period of time						
Fatigue						
Chronic Pain						

MEDICAL INFORMATION FORM

FUNCTIONAL IMPACT, cont'd:						
Skills/Abilities	**No Impact**	**Mild Impact**	**Moderate Impact**	**Severe Impact**	**Not sure**	**Comments/ Accommodation Recommendations**
SENSORY						
Vision (best corrected) – please describe						
Hearing (best corrected) – please describe						
Speech – please describe						
SOCIAL/EMOTIONAL						
Appropriate in-class and group work interactions						
Ability to do class presentations						
Stress management						
Effectively control emotions						
OTHER						
Attendance/Absence from class						
Participating in a work/field placement						
No more than 1 major test/exam per day						

SECTION D: Certification of Health Care Professional *(PLEASE PRINT)*

I, _____, am a legally qualified health care professional and this report contains my findings and is considered opinion at this time, within my scope of practice.

Signature: _____ **Date**: _____

Licence/Registration # _____
Email: _____
Type of Health Practitioner: ❒ Physician ❒ Psychiatrist ❒ Psychologist ❒ Other _____

Address or Business Stamp:

Please retain a copy of this form in your patient/client's records.

SECTION E: Returning completed forms

Completed forms may be returned to us by the student or directly by the health care professional. When possible, please send documentation electronically in advance of an appointment by either email at calcs@centennialcollege.ca or by fax to 647-689-2932. If unable to send electronically, we will accept documentation submitted in person.