Student Accessibility Services
Medical Documentation for ADHD

NOTE: This form must be signed and stamped by a medical practitioner. Please Print.

Date Completed (mm/dd/yyyy): _____/_____/_____

SECTION TO BE COMPLETED BY STUDENT

Student's Last Name: _____

Student's First Name: _____

Student Number: _____

Address: _____

City: _____

Postal Code: _____

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

Phone (Home/Cell): _____

Email Address: _____ May we contact you by email? _____

SECTION TO BE COMPLETED BY MEDICAL PRACTITIONER

Please use office stamp as well as signature:

Name: _____
Address:_____
Phone Number: _____

How long have you known this student? _____

Nature of Primary Disability: _____

Date of onset/diagnosis:
_____

Summary of symptoms. Please be specific.
_____
_____
_____

Identify relative strengths of the student:
_____
_____
_____

As much as possible please comment on the impact of the student's disability on their academic work
_____
_____
_____
_____
_____
_____

Primary Disability is:

❑ permanent – a functional limitation that will significantly impact student over course of their academic career

❑ temporary – need of academic accommodations while receiving treatment (approx. 1-3 terms)

Please list any additional disabilities:
_____
_____
_____

Duration and Frequency of Treatment (if applicable):
_____
_____
_____

Possible side effects of medication(s) on student's academic performance:
_____
_____
_____

Please indicate the potential academic impact of this student's disability(ies) on:

	Little effect								**Severe effect**	
Concentration	1	2	3	4	5	6	7	8	9	10
Processing information	1	2	3	4	5	6	7	8	9	10
Retaining information	1	2	3	4	5	6	7	8	9	10
Meeting deadlines	1	2	3	4	5	6	7	8	9	10
Group participation	1	2	3	4	5	6	7	8	9	10
Exam situations	1	2	3	4	5	6	7	8	9	10

If any of the above effects are severe, please elaborate:

_____
_____
_____

Are you aware whether or not the student has received any academic accommodations in the past? If so, what were they?

_____
_____
_____

I give consent for Student Accessibility Services to contact my medical practitioner, if necessary, regarding the information provided in this document:

Student's Signature: _____

Practitioner's Name (please print): _____

Practitioner's Signature: _____

Medical Practitioner's License Number: _____

****Please ensure that this form is completed in full. Incomplete forms will not be accepted.**

****Note to student:** If you have other relevant documentation, you may include copies of them with this registration package. These additional documents are not intended to replace the SAS registration package.Please note - additional documentation may be requested.