# 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): _____/_____/_____**

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**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? _____

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**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** | | | | **Moderate 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?

_____
_____
_____

Student's Signature: _____

Practitioner's Name (please print): _____

Practitioner's Signature: _____

Medical Practitioner's License Number: _____

**Student Consent:** completion of this section is voluntary, however, if you elect not to provide your consent at this time and in the event that further information is required there may be delays in the provision of your accommodation.

I give consent for Student Accessibility Services to contact my medical practitioner or registered psychologist to discuss the information provided in this document if necessary to clarify the information provided regarding functional restrictions and limitations or if there are questions about complex academic accommodation.

Student's Signature: _____

Date:(mm/dd/yyyy): _____

**Note to student:** this form is intended for students who do not have a full psycho-educational assessment which documents their learning needs and how their ADHD impacts their academics. Students who submit this form should be aware that they might be requested to go through additional assessment prior to receiving full accommodations.

Students should upload an electronic copy of this completed form to the online "Registration Form" available from the New Students page of our Website: **https://accessibility.students.yorku.ca/new-students.** If you have other relevant documentation, you may include copies of it. Please note - additional documentation may be requested.