Queen's Student Accessibility Services
Queen's University
Côté Sharp Wellness Centre, Mitchell Hall
69 Union Street | Kingston, ON | K7L 3N6
613-533-2506
https://www.queensu.ca/studentwellness/accessibility-services/

Verification
PHYSICAL/HEARING/VISION

PART A – *Student Information*

STUDENT INFORMATION

Last Name: ________________________ Preferred/Given Name: _______________________

Date of Birth: ______________________ Student Number: ____________________________

Queen's Net ID: ____________________ Phone Number: _____________________________

DISCLOSURE & CONFIDENTIALITY

- Medical diagnosis is not required to receive accommodations.
- To recommend appropriate accommodations QSAS uses information about functional impacts (i.e., how your medical diagnosis might impact you at university).
- QSAS will hold all medical information confidentially. Information about medical diagnosis will not be shared without your express and written consent.
- All information on this form will be kept strictly confidential, even if consent to share medical diagnosis is not provided.

Do you consent to your medical diagnosis being identified on this form?

YES ☐ **NO** ☐

Do you consent to having this form shared with Queen's Student Accessibility Services (QSAS)?

YES ☐ **NO** ☐

Personal information is collected under the authority of the *Queen's University Royal Charter, 1841,* as amended, and will be used to provide disability-related services and accommodations for studies at university. Questions regarding the collection or use of this personal information should be directed to Manager, QSAS, 69 Union Street, Kingston, ON, K7L 3N6, (613) 533-2506, accessibility.services@queensu.ca

PART B – *Health Care Information*

VERIFICATION OF IMPACT

If student has consented above to disclose their medical diagnosis, please provide a diagnostic statement below.

DURATION

☐ **Permanent:** *Anticipated to impact student throughout academic career at Queen's.*

☐ **Temporary:** *Accommodations will be provided until the end of the following academic term*, unless alternate duration specified below.*

Alternate duration ______________/_______________ *(MM,YR)*

☐ **Provisional:** *Monitoring/Assessment under way*

Anticipated assessment completion date __________/__________/__________ *(DD, MM, YR)*

Is student's condition expected to decline? YES ☐ NO ☐

*Accommodations provided **Spring/Summer** expire **Dec. 31**; **Fall** expire **Apr. 30**; **Winter** expire **Aug. 31**

MEDICAL INFORMATION – FUNCTIONAL IMPACTS - *Mobility*

Is functioning restricted to certain times of day? Morn. ☐ Aft-noon. ☐ Even. ☐

Does student require **personal care support**? YES ☐ NO ☐

(provide more information below)

☐ Attending Class
☐ Toileting
☐ Navigation
☐ Eating
☐ Other ____________________________

Could student's academic success be impacted by any ongoing treatment (medication or otherwise)? YES ☐ NO ☐

If yes, please specify any side effects that may impact the student's academic functioning

AIDS/SUPPORTS - *Mobility*

- ☐ Wheelchair/Scooter
- ☐ Walker
- ☐ Arm Brace
- ☐ Other: ____________________________
- ☐ Cane/Crutch/Walking Stick
- ☐ Ergonomic Chair/Desk
- ☐ Leg Brace
- ☐ Other: _____________________________

MEDICAL INFORMATION – FUNCTIONAL IMPACTS - *Hearing*

Severity with Corrective Technology			
Left Ear	☐ Mild	☐ Moderate	☐ Severe
Right Ear	☐ Mild	☐ Moderate	☐ Severe
Severity w/out Corrective Technology			
Left Ear	☐ Mild	☐ Moderate	☐ Severe
Right Ear	☐ Mild	☐ Moderate	☐ Severe
Date of Onset ______/______/_______	(DD, MM, YR)		

AIDS/SUPPORTS - *Hearing*

- ☐ Hearing Aid(s)
- ☐ FM System
- ☐ Real-Time Captioning
- ☐ Other: __________________________
- ☐ Cochlear Implant(s)
- ☐ ASL./English
- ☐ Video Captioning
- ☐ Other: ___________________________

MEDICAL INFORMATION – FUNCTIONAL IMPACTS - *Vision*

Indicate severity of loss of the following:			
Visual Field	☐ Mild	☐ Moderate	☐ Severe
Depth Perception	☐ Mild	☐ Moderate	☐ Severe
Colour Perception	☐ Mild	☐ Moderate	☐ Severe
Date of onset: ______/______/_______	(DD, MM, YR)		
Does student require alternatives to print format?	☐ YES	☐ NO	

AIDS/SUPPORTS - *Vision*

- ☐ Screen-Reading Technology
- ☐ White Cane
- ☐ GPS for Wayfinding
- ☐ CCTV
- ☐ Text Enlargement (e.g., magnifiers)
- ☐ Dark or Other Special Glasses
- ☐ Guide Dog
- ☐ Other: _________________________

RESTRICTIONS & LIMITATIONS

Symptoms/Restrictions	N/A	Mild to Moderate	Serious to Severe	Comments
Difficulty with…				
…performing tasks of daily living				
…managing pain				
…energy level				
…walking short distances				
…prolonged standing [______minutes]				
…prolonged sitting [______minutes]				
…climbing stairs				
…lifting weight [______lbs]				
…range of motion				
…balance and coordination				
…fine motor dexterity				
…speech				
…concentration/sustained attention				
…ringing in the ears				
…understanding speech with background noise				
…following/responding to conversation				
…hearing in classroom				
…other				

ACADEMIC IMPACTS

	N/A	Mild to Moderate	Serious to Severe	Comment
Attending Class				
Taking Notes				
Reading				
Writing Assignments				
Completing Exams				
Delivering Presentations				
Meeting Assignment Deadlines				
Participating in Group Activity				
Other				

COURSE LOAD

Would you recommend a Reduced Course Load for this student? YES ☐ NO ☐

Additional Information on course load (if required)

HEALTH CARE PROFESSIONAL INFORMATION

Name (please print)	
Signature	
Date (DD, MM, YR)	
Specialty	
Registration/License No.	
Facility Name and Address (Use Official Stamp if Available	
Phone	
Email	