



Disability Resources
 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 DISABILITY RESOURCES

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 Disability Resources 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 Disability Resources Coordinator at Red Deer College, Box 5005, Red Deer, Alberta, T4N 5H5, Telephone: 403.357.3629.

DOCUMENTATION OF DISABILITY OR MEDICAL CONDITION

Disability Resources 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
<input type="checkbox"/> I authorize the below named professional to provide the information contained in this report to Disability Resources 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 Disability Resources 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	<input type="checkbox"/> MEDICAL	<input type="checkbox"/> MENTAL HEALTH	<input type="checkbox"/> OTHER
Is this person a regular patient of yours?	<input type="checkbox"/> YES	<input type="checkbox"/> 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):

<input type="checkbox"/> Extended time for tests/exams (specify amount below)	<input type="checkbox"/> Exams to be completed in reduced-distraction environment
<input type="checkbox"/> The use of a recording device to record lectures	<input type="checkbox"/> Reducing the student's full-time program course load
<input type="checkbox"/> Priority seating in the classroom/exam room	<input type="checkbox"/> Allowing short breaks for physical repositioning; for washroom breaks
<input type="checkbox"/> Assistive software and/or technology – Please specify below	<input type="checkbox"/> 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: <input type="checkbox"/> Family Physician <input type="checkbox"/> Psychologist/ Psychiatrist <input type="checkbox"/> Other: _____
Telephone:	Email:

SUMMARY OF DISABILITY DOCUMENTATION REQUIRED FOR STUDENT AID FUNDING

Type of Disability	Documentation Required by Student Aid
Deaf, Hard of Hearing	<ul style="list-style-type: none"> Audiologist report, or Letter from a physician with an explanation of the degree of hearing loss
Blind, Visually Impaired	<ul style="list-style-type: none"> Specialist report, or Letter from a physician with a description of the functional limitations
Learning Disability	<ul style="list-style-type: none"> Psycho-educational report from a Psychologist, or Neuro-psychological report
Speech	<ul style="list-style-type: none"> Speech language pathologist report
Mobility/Agility Impairment	<ul style="list-style-type: none"> Specialist report, or Letter from a physician with an explanation of the nature of the mobility/agility impairment (functional limitation)
ADD / ADHD	<ul style="list-style-type: none"> Psychologist report, or Neuro-psychological report, or Letter from a psychiatrist, or Letter from a physician with details about the diagnosis
Psychiatric or Psychological	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Psychologist report, or Letter from a physician with details about the diagnosis
Brain Injury/Cognitive Impairment	<ul style="list-style-type: none"> Neuro-Psychological report, or Brain injury/cognitive impairment report/assessment
Other Permanent Disability such as:	<ul style="list-style-type: none"> Chronic Fatigue: a detailed letter from physician Irlen Syndrome: assessment report from a certified Irlen Screener