St. Lawrence College

Student Services

CAAS - Counselling & AccessAbility Services

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CONFIRMATION OF DISABILITY FORM

Section 1 Student Consent for Disclosure of Information

This section to be completed by student/applicant (please print)

Name: ________________________________ **D.O.B.:** _________/_________/___________
month day year

Preferred Phone: (____)__________________ **Email:** ______________________________

Academic Program: ____

In accordance with the Ontario Human Rights Commission, students are not required to provide a diagnosis to receive academic accommodations or other support services. A health care practitioner must, however, provide documentation confirming a disability and the resulting functional limitations that are likely to affect academic functioning.

To access government financial aid opportunities for students with disabilities, the type of disability (see Section 2) must be disclosed along with the related functional impairments. To be eligible for disability-related **Canada Student Grants**, students must have a permanent disability, which is defined as a chronic functional limitation caused by a physical or mental impairment that restricts the student's ability to perform the daily activities necessary to participate in studies at the post-secondary level or in the labour force.

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA) all information will be kept confidential.

I have read and understand the implications noted above and I authorize my health care practitioner to disclose the following information. (Please check one of the three boxes below to indicate your decision about the release of your information.)

- ☐ my diagnosis, type of disability, and functional limitations (permits accommodations and funding)
- ☐ my type of disability and functional limitations (permits accommodations and funding)
- ☐ my functional limitations only (permits accommodations only; no funding)

Student Signature: _________________________________ **Date:**____/____/_______
month day year

St. Lawrence College maintains compliance with all privacy requirements, including the Freedom of Information and Protection of Privacy Act (FIPPA), the Personal Information Protection and Electronic Documents Act (PIPEDA), and the Personal Health Information Privacy Act (PHIPA). The Privacy Commissioner of Ontario can be reached at 1800-387-0037.

Section 2 — Type of Disability and/or Diagnosis

***ATTENTION HEALTH CARE PRACTITIONER*:** This form will be used as one of the criteria to determine eligibility for academic accommodations, support services, and financial supports. Please indicate information below according to the student's consent on Page 1. If applicable, include copies of relevant assessments.

☐ **Mental Health Disability** (e.g., generalized anxiety disorder, major depressive disorder)
Diagnosis:

☐ **Attention/Concentration Disability** (e.g., ADD/ADHD)
Diagnosis:

☐ **Functional/Mobility Impairment** (e.g., paraplegia, muscular dystrophy, cerebral palsy, spina bifida)
Diagnosis:

☐ **Social/Communication Disability (**e.g., autism spectrum disorder)
Diagnosis:

☐ **Medical Disability** (e.g., epilepsy, chronic pain, heart condition)
Diagnosis:

☐ **Visual Impairment**
Diagnosis: Visual acuity: ______________ Visual field: _____________

☐ **Hearing Impairment**
Diagnosis:
Please indicate level of hearing loss:

Left:	☐ Mild	☐ Moderate	☐ Severe	☐ Profound
Right:	☐ Mild	☐ Moderate	☐ Severe	☐ Profound

☐ **Acquired Brain Injury**
Diagnosis:

☐ **Other Type of Disability (specify):** ____

Section 3a — Functional Limitations: Effects on Physical Functioning

Check all that apply:

☐ Ambulation ☐ Stair Climbing ☐ Lifting/Carrying/Reaching ☐ Grasping/Gripping/Dexterity

☐ Sitting ☐ Standing ☐ Other – Specify: ______________________________________

Describe effect(s) and severity:	

Section 3b Functional Limitations: Effects on Cognitive and/or Behavioural Functioning

Check all that apply:

☐ Attention and Concentration
☐ Communication
☐ Organization & Time Management
☐ Stress Management
☐ Memory
☐ Emotion regulation
☐ Information Processing (verbal/written)
☐ Social Interactions
☐ Other (specify): ___________________

Describe effect(s) and severity:	

Section 4 Effects of Medication on Functioning

Is the patient currently taking any prescription medications that may affect the patient's participation in an educational environment?

☐ No

☐ Yes

Describe effect(s) and severity:	

Section 5 Recommended Supports

Optional – Check all that apply.

☐ The patient is advised to consider a reduced course load.

☐ The patient requires specialized equipment and/or services in order to participate in post-secondary education.

Specify equipment and/or services required:	

Section 6 Disability Status

To be eligible for disability-related Canada Student Grants, students must have a permanent disability. Please choose ONE of the following statements that best describes your patient.

☐ Patient's disability is **temporary**.

Anticipated duration of disability: ____

☐ Patient's disability is **permanent** with ongoing (chronic or episodic) symptoms that will likely restrict their ability to perform the activities necessary to fully participate in post-secondary studies. **Note:** Where a student has been symptom-free for the last three or more years, it may be presumed that the disability is not considered chronic and would not be expected to affect the individual's ability to function academically.

☐ I am **monitoring** this student's condition to determine a diagnosis.

This student has been my patient for (circle): **More than 2 years** **Less than 2 years** **Walk-In/1st Visit**

Date you last saw this patient: __________________
(month/day/year)

Section 7 Health Care Practitioner Information

Name: ____

Type of Health Care Practitioner: ____

Address: ____

Tel: ____________________________________ Fax: ____

I certify that the information provided on this form is accurate and the patient identified above experiences the disability-related educational barrier(s) indicated.

Signature of Health Care Practitioner: ________________________________ Date: ____/_____/______
month **day** **year**

Official Stamp (if applicable):