Medical Questionnaire

Accommodations are fundamental to support students with disabilities, and Horizon aims to provide an accessible learning environment for all our students.

Students are responsible to ensure Horizon is aware of their request for accommodations and to provide Horizon with the professional diagnosis and recommendations as outlined below.

Horizon works to provide accommodations for students with permanent or temporary disabilities, including those accommodations listed on this form. In order to authorize substantial academic accommodations, Horizon policy requires accommodations to be recommended by health care practitioners. Such accommodations shall not compromise academic requirements or standards of any course or program.

To access accommodations:

- **a student with a medical disability** must have this form completed by a licensed health care practitioner, authorized by their licensing body to diagnose.
- **a student with a learning disability does not complete this form.** A student with a learning disability must submit a psycho-educational assessment completed by a registered psychologist.

The information provided will not become part of the student's educational record, but will be kept in the student's file at Horizon, where it will be held strictly confidential. This form may be released to the student at his or her request.

Student Information

Last Name	First Name		
Address – Apt. Number, Street, Box Number	City/Town	Province	Postal Code
Date of Birth (dd/mm/yyyy)	Telephone	Cell Phone	
Program	Year in Program	Student Number	

Licensed Health Care Practitioner (authorized by licensing body to diagnose)

Last Name	First Name		
Address – Apt. Number, Street, Box Number	City/Town	Province	Postal Code
Profession	License Number	Telephone	Fax
How long have you been treating this patient	Signature	Date (dd/mm/yyyy)	

Student Authorization for Health Care Practitioner to Release Medical Information

I hereby authorize the information on this form to be released to HCS and/or for HCS to contact the practitioner who completed this form.

Student Signature	Date (dd/mm/yyyy)
Parental Signature (For students under 18)	Parent Printed Name
Witness Signature:	Witness Printed Name:

Name of Student_____

Disability Information

A disability may impact the student's daily living, academic activities, and/or ability to participate fully at HCS. Limitations may be the result of a physical disability, neurological impairment, mental health disorder, chronic illness, addiction, or temporary medical condition (for example, a broken limb or resulting from surgery).

Diagnosis or, if mental health condition, DSM nomenclature. For example, MDD or GAD	**Date diagnosed (dd/mm/yyyy)**
1.	1.
2.	2.

☐ **Permanent disability**

Permanent disability: a functional limitation caused by a physical or mental impairment which restricts a person's ability to perform the daily activities necessary to participate fully in post-secondary studies or in the labour force, and is expected to remain with the person for the person's expected life.

☐ continuous

☐ episodic

☐ **Temporary disability** ☐ **Estimated Time Frame**_____

Impact of disability on functions necessary to participate in post-secondary studies.

Life and Academic Activities	No impact	Mild impact	Moderate impact	Severe impact	Unknown
Concentration					
Memory					
Sleep					
Eating					
Social interactions					
Self-care					
Managing internal distractions					
Managing external distractions					
Timely completion of tasks					
Regular and timely attendance					
Making and keeping appointments					
Stress management					
Organization					
Writing					
Note taking					
Examinations/evaluative situations					
Information processing (written/verbal)					
Retaining of information					
Group participation					
Oral presentations					
Other:					

Name of Student_____

Academic Accommodations

Health Care Practitioner initials those accommodations that will ensure the student's access to HCS academic programing and the opportunity for academic success.

_____ **May miss class occasionally** – due to the impact of the disability on the student's health

_____ **May require extensions for assignments** – may not be able to complete assignments on time due to illness, lower cognitive processing, or reduced ability to manage time/ planning

_____ **Note taking assistance** – to compensate for lectures the student is unable to attend due to the disability, or to reduce anxiety about whether or not something important has been missed due to inability to manage external distractions

_____**Required to record lectures** – some medications/ disabilities interfere with the student's ability to focus on both the lecture and making notes.

Exam Accommodations

_____**Extended time** – to compensate for being distractible or the slowing of cognitive processing due to either the disability or medication

_____ **Quiet space** – to reduce distractions and lower anxiety levels

_____**Use of computer** – if the student's ability to write is affected or if a computer allows a student to be more focused and organized

_____**Reader** – counteracts low reading skills, vision problems, and/or attention issues

_____**Verbal** – used when the student is unable to write or use computer

Do you consider this student to be in stable condition and capable of sustaining normal academic stress with appropriate supports?

☐ Yes ☐ No

If **No**, please explain

Other Accommodations recommended:

PLEASE SUBMIT THE COMPLETED FORM TO THE REGISTRAR

(At the Main Office or by email, rquiring@horizon.edu)

HCS Office Use Only:

Populi: ☐

Academic Assistance Notified: ☐