Glendon Accessibility, Well-Being and Couselling Centre
Registration Information for Students with ADD/ADHD

Accessibility, Well-Being and Couselling Centre

2275 Bayview Ave
Glendon Hall, 111A
Toronto, On Canada
M4N 3M6
T 416 487 6709
F 416 440 9237
www.glendon.yorku.ca/counselling

Dear Student,

If you wish to register with Glendon Accessibility Services, you must provide relevant **psychological** or **medical** documentation.

The attached form is for students who do not have a full psycho-educational assessment which documents their learning needs and how their ADD/ADHD impacts their academics. Students who submit this form should be aware that they might be requested to go through additional assessment through Learning Disability Services at Keele Campus prior to receiving full accommodations.

During peak periods it is possible that from the time that your documentation reaches our office, it can take up to a **maximum of 2 weeks** for you to see your counsellor for your initial appointment.

Many accommodations take time to implement. In some cases, students who are approaching us in the middle or near the end of a term might only be able to fully access their accommodations the next term. Extended time for tests/exams needs to be arranged at the **start** of each academic term.

You may find it helpful to read information specific to your disability at http://www.yorku.ca/cds/lds. In the interim, if you have any urgent questions that are not answered on the website, please do not hesitate to contact us at counselling@glendon.yorku.ca or 416-487-6709.

Glendon Accessibility, Well-Being and Couselling Centre

Medical Documentation for ADHD/ADD

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NOTE: This form must be signed and stamped by a medical practitioner. Please Print.

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? _____

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

_____
_____
_____
_____

Statement of Permance of Disability :

- ❑ **Permanent disability** -The student's disability (or disabilities) is permanent with ongoing (chronic or episodic) symptoms that will restrict his/her ability to perform the daily activities necessary to fully participate in postsecondary studies or in the labour force and the disability is expected to remain for his/her lifetime

- ❑ **Temporary** – The student's disability is temporary (approx. 1-3 terms). Please indicate the anticipated duration of the disability .

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 the following areas:

	Little impact					**Moderate impact**				**Severe impact**
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 are " Severe Impact", please elaborate:

_____

_____

_____

Academic accommodations are intended to level the playing field while maintaining academic integrity. Based on your knowledge of this student disability, please list specific disability related academic supports/accommodations that you would recommend to assist the student (e.g., to complete assignments, to write tests/exams). Please provide a rationale for these academic accommodations:

_____

_____

_____

_____

_____

****Please ensure that this form is completed in full. Incomplete forms will not be accepted.**

**Please return completed form to student or fax this form to: Sylvie Aubin, Accessibility Counsellor, 416-440-9237 (Fax Number)

Date Completed (mm/dd/yyyy): _____

Practitioner's Name (please print): _____

Practitioner's Signature: _____

Medical Practitioner's License Number: _____

Student Consent

I give consent for Accessibility Services within Accessibility, Well-Being and Counselling Centre to contact my medical practitioner or registered psychologist to discuss the information provided in this document.

Student Signature: _____

Date(mm/dd/yyyy): _____

**Note to student: If you have other relevant documentation, you may include copies of it with this registration package. These additional documents are not intended to replace the registration package. Please note: additional documentation may be requested.