



## Disability Services Registration Information for Students with ADHD

Dear Student,

If you wish to register with Learning Disability 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 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 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 our website, please do not hesitate to contact our receptionist at (416) 736-5383 who will direct you to the appropriate person.

Please note that students enrolled at **Glendon College** need to contact Counselling & Disability Services, Glendon Site at (416) 487-6709.

We are looking forward to working with you.

Regards,

A handwritten signature in cursive script that reads "M. Barnes".

Maureen Barnes, B.Ed., M.A  
Manager, Learning Disability Services



## Counselling and Disability Services Medical Documentation for ADHD

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

**Date Completed (mm/dd/yyyy):** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

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### 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? \_\_\_\_\_

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### 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  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Primary Disability is:

- permanent – a functional limitation that will significantly impact student over course of their academic career
- temporary – need of academic accommodations while receiving treatment (approx. 1-3 terms)

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:

	Little effect			Moderate effect				Severe effect		
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 effects are severe, please elaborate:

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Are you aware whether or not the student has received any academic accommodations in the past? If so, what were they?

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I give consent for Disability Services within Counselling and Disability Services to contact my medical practitioner, if necessary, regarding the information provided in this document:

Student's Signature: \_\_\_\_\_

Practitioner's Name (please print): \_\_\_\_\_

Practitioner's Signature: \_\_\_\_\_

Medical Practitioner's License Number: \_\_\_\_\_

**\*\*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: Maureen Barnes , Manager, Disability Services, 416-736-5565 (Fax Number).

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

