ALPHACRUCIS COLLEGE

Disability Support
Supporting Documentation

Supporting Documentation

Please return this form to DSO@ac.edu.au

The following information must be completed by an accredited health professional*. This form is for one disability, any additional disabilities will need a separate form.

**Such as a psychologist, occupational therapist, physiotherapist, general practitioner or other specialist.*

Student Details

Full name: _____ Student ID: _____

I hereby give authority for _____ (Practitioner's name)

to release information relating to my disability to the Student Support Office at Alphacrucis College.

Student signature: _____ Date: _____

Health Professional Details

Full Name	
Profession	
Address	
Phone contact	
Email	
Provider number	

How many times as this student been seen at your practice during the past 12 months about their disability/condition (including this appointment)? _____

I authorise the Student Support Office to contact me or my office to confirm the authenticity of this document.

Professional's signature	
Date	

Disability Information

Diagnosis				
Date diagnosed				
Disability type	☐ Physical	☐ Vision	☐ Hearing	
	☐ Learning		☐ Medical	
	☐ Psychological		☐ Neurological	
Severity of condition	☐ Mild	☐ Moderate	☐ Severe	☐ Profound
Disability Status	☐ Ongoing stable		☐ Ongoing fluctuating	
	☐ Temporary stable	Duration:		

	☐ Temporary fluctuating	Duration:			
Valid for	☐ _____	☐ 6 months	☐ 1 year	☐ 2 years	☐ 3 years
Medication or treatment plan					

Disability impact on studies

Please indicate the impacts of the disability and medication or treatment on the student's studies.			
☐ Concentration	☐ Task switching	☐ Disrupted thought processes	☐ Hearing
☐ Attention	☐ Motivation	☐ Avoidance	☐ Sight
☐ Focus	☐ Engagement	☐ Reduced mobility	☐ Other, please specify
☐ Mental fatigue	☐ Social withdrawal	☐ Pain/discomfort	
☐ Information processing	☐ Psychosis	☐ Physical fatigue	
☐ Distraction	☐ Stress tolerance	☐ Reduced physical ability	
☐ Memory	☐ Decision making skills	☐ Disruptive symptoms	
☐ Organisation	☐ Variable moods	☐ Frequent illnesses	
☐ Planning	☐ Agitation	☐ Reduced communication	
☐ Prioritisation	☐ Procrastination	☐ Disrupted sleep	

Description of condition and impacts on studies (Please explain in detail how the student's disability is likely to impact on their academic performance and engagement at college):

Impacts of medication/treatment in studies:

Recommendations for adjustments/support

Based on the impacts previously outline in this document, please note below any specific recommendations you have about the type of support this student needs.

Safety plan

Does this student require a medical or mental safety plan? ☐ Yes ☐ No

If yes, please fill out of the safety plan on the next page or include a copy of an existing plan.

_____

The Safety Plan will be kept on file by Student Support so that we have this information available in the case of an incident where a student is in crisis. The Safety Plan will also be given to personnel on your campus to assist you in the case of a crisis.

Safety Plan

Student Details	
Full name:	
Student ID:	
Warning signs of health crisis	
1. 2. 3. 4. 5.	
Student's self-management or preventative measures to avert a crisis	
1. 2. 3. 4. 5.	
Emergency Contacts (Medical and Personal) if a crisis occurs	
Professional Contact 1 Name: Phone:	Professional Contact 2 Name: Phone:
Personal Contact 1 Name: Phone:	Personal Contact 2 Name: Phone:
Signature of medical or health professional providing safety plan	
Name	
Signature	Date:

Thank you.