

Medical Evidence Form

Student details

Surname

First Name

Address

Date of Birth

Diagnosis / working diagnosis (if it is not possible to give a diagnosis or working diagnosis please explain why)

In your professional opinion will this diagnosis last for 12 months or more?

Yes

No

Unknown

Main symptoms of the condition

(Please include severity, pattern and duration of symptoms if possible)

Impact on daily activities and studies

Does their condition significantly compromise reading or writing speed?

Yes

No

Unknown

If yes, in your opinion what would meet their needs in timed exams? (select only one)

Use of a computer

Scribe

Is their performance likely to be impacted by prescribed medication taken? (please detail in comments)

Yes

No

Unknown

Would you recommend rest breaks during exams?

Yes

No

Unknown

Additional comments:

Please comment on anything else which may impact on ability to study e.g. concentration, memory or motivational difficulties, ability to sit during long lectures or exams, details of medications which may compromise performance.

Campus accommodation and parking

Does this student's mobility require them to live a very short distance from the teaching rooms?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Could travelling short distances be detrimental to this student's health?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Does the nature of their condition prevent them from using public transport?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Does this student have a condition which necessitates en-suite facilities?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Please comment on anything else which may help us to assess this student's support needs			
Your Job Title			
The nature of your professional involvement with this student (if not apparent from job title)			
The name and contact details of the organisation you work for (where possible please use your agencies' stamp)			
Your signature X	Date		

If you do not wish this medical evidence to be made available to the student please let us know

Please return this form to: Student Wellbeing & Inclusivity Service, Silberrad Student Centre, University of Essex, Wivenhoe Park, Colchester, Essex, CO4 3SQ.

Email to : include@essex.ac.uk Tel: 01206 874635