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

<table>
<thead>
<tr>
<th>Does this student’s mobility require them to live a very short distance from the teaching rooms?</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Could travelling short distances be detrimental to this student’s health?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Does the nature of their condition prevent them from using public transport?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
<tr>
<td>Does this student have a condition which necessitates en-suite facilities?</td>
<td>Yes</td>
<td>No</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

Please comment on anything else which may help us to assess this student’s support needs

<table>
<thead>
<tr>
<th>Your Job Title</th>
</tr>
</thead>
</table>

The nature of your professional involvement with this student (if not apparent from job title)

<table>
<thead>
<tr>
<th>The name and contact details of the organisation you work for (where possible please use your agencies’ stamp)</th>
</tr>
</thead>
</table>

Your signature

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>

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:  disab@essex.ac.uk  Tel: 01206 874635