

MEDICAL USE OF AN IMPAIRING SUBSTANCE

REPORT FORM

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***SECTION A: To be completed by Loyalist College:***

Is this student in a safety-sensitive program?

[ ] No

[ ] Yes (if Yes, please identify safety-sensitive tasks below)

[ ] Driving a vehicle [ ] Working with high voltage

[ ] Driving a forklift [ ] Administering medications

[ ] Working from heights [ ] Operating medical equipment

[ ] Operating power tools/equipment [ ] Responsible for safety/wellbeing of others

[ ] Working with hazardous chemicals [ ] OTHER: Please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***SECTION B: To be completed by Student:***

I hereby authorize my care provider, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to complete this report and return to AccessAbility Services.

***Student Signature*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***Date***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***SECTION C: To be completed by Attending Physician:***

As part of our commitment to Health and Wellness, Loyalist College is focused on proactively creating a culture of wellness for the betterment of students, staff and faculty. The above-named individual is seeking special provisions because they recognize that their medication affects their ability to learn. Please note that as if January 1, 2019, smoking is prohibited on College property. If medical cannabis is being prescribed, Loyalist College encourages alternative methods of administration.

In our efforts to make appropriate arrangements that considers the safety of this individual and others on the campus, please complete the following information:

|  |  |
| --- | --- |
| What is the substance? |  |
| What is the strength/dosage? |  |
| What is the frequency of use? |  |
| What is the method of administration (i.e. oral, topical, smoked, or inhalation)? |  |

1. Have you investigated other therapies as an alternative to this substance? [ ] Y [ ] N
2. What type of support or arrangement will this individual require?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please identify the potential cognitive effects on functional abilities:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Low/no impact** | **Moderate impact** | **Significant impact** |
| Alertness  |   |   |   |
| Orientation  |   |   |   |
| Attention/Concentration |   |   |   |
| Memory |   |   |   |
| Judgment |   |   |   |
| Mood |   |   |   |
| Fatigue |   |   |   |
| Psychomotor function |   |   |   |

1. In your opinion, is this individual safe to perform the safety-sensitive tasks identified in section (A) above? **[ ] Yes [ ] No**

|  |
| --- |
| 1. **If prescribing medical cannabis**, please attach a photocopy of the prescription.

**[ ] Photocopy is attached [ ] N/A** (substance in question is not medical cannabis) |
|  |

1. Please identify any further restrictions required for this student:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is the anticipated duration for this medical arrangement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. When is your next follow-up visit with this patient? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Attending Physician Name |  | Signature |  | Date |

Thank you for completing this form. Should you have any questions or require further information, please feel free to contact me at 613-969-1913 ext. 2519.