**** **Craigslea State High School**

 **Access Arrangements and Reasonable Adjustments**

**Short Term (AARA) Application form**

**Confidential Medical Report**

**Return via email to** AARA@craigsleashs.eq.edu.au

Medical reports may only be completed by the student’s general practitioner (GP) or a medical specialist (registered under Queensland’s *Medical Practitioners Registration Act 2001*). The health professional providing a report must not be related to the student or employed by the school. The information provided needs to be current and relate to the relevant assessment period.

Information provided in this report is treated is strictest confidence and is only used for the purpose of determining the student’s AARA application.

*If the health professional does not use this report form, they must supply a current medical report containing all of the following information.*

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| --- |
| **Student Details** |
| Name: | Click or tap here to enter text. | Roll Class: | Click or tap here to enter text. |
| Date: | Click or tap here to enter text. | LUI: |  |

**Period of AARA** [ ] Unit 1 [ ] Unit 2 [ ] Unit 3 [ ] Unit 4

**AARA eligibility details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Time-frame** | **Category** | **Examples** | **Details** |
| [ ]  Permanent[ ]  Temporary[ ]  Intermittent | [ ]  Illness and Misadventure  | Unforeseen circumstances/ unexpected event, injury or diagnosed illness, bereavement, trauma | *Please indicate and briefly describe the disability, condition or circumstance:*  |
| [ ]  Social/Emotional | Anxiety, Depression, ODD, OCD |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Subject** | **Teacher + HoD** | **Assessment due date** | **Requested****extension date** | **Description of task** |
| Click or tap here to enter text. | Enter text | Enter text | Enter text | Click or tap here to enter text. |
| Enter text |
| Click or tap here to enter text. | Enter text | Enter text | Enter text | Click or tap here to enter text. |
| Enter text |
| Click or tap here to enter text. | Enter text | Enter text | Enter text | Click or tap here to enter text. |
| Enter text |
| Click or tap here to enter text. | Enter text | Enter text | Enter text | Click or tap here to enter text. |
| Enter text |
| Click or tap here to enter text. | Enter text | Enter text | Enter text | Click or tap here to enter text. |
| Enter text |

|  |
| --- |
| **Student Details** |
| **Student****Signature** |  | **Date** |  |
| **Parent/carer Signature** (if student is under 18) |  | **Date** |  |

|  |
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| **This section is to be completed by a health professional** |
| **Diagnosis** |
| **Patient (Student) Name:**  |  |
| **Diagnosis:** |  |
| **Date of diagnosis:** |  |
| **Date of occurrence/onset:** |  |

|  |
| --- |
| I consider that the effect of the impairment arising from the medical condition is/was: |
| 🞎 mild | 🞎 moderate | 🞎 severe |
| I consider that the student is/was: |
| 🞎 disadvantaged due to temporary medical condition |
| 🞎 unfit to participate in assessment due to a temporary medical condition from \_\_\_/\_\_\_\_/\_\_\_\_ (date) to \_\_\_/\_\_\_\_/\_\_\_\_ (date). |
| 🞎 unfit to participate in assessment due to a deterioration in a chronic condition from \_\_\_/\_\_\_\_/\_\_\_\_ (date) to \_\_\_/\_\_\_\_/\_\_\_\_ (date). |
| If the student was affected for less than a full day, comment on the amount of time the student was affected during a timed assessment, e.g. second half of the exam session.  |
|  |
| Professional recommendations for assessment adjustments. |
|  |

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| --- |
| **Health Professional Details** |
| **Name:** |  |
| **Profession:** |  |
| **Phone:** |  |
| **Specialty/qualifications:** (if applicable) |  |
| **Place of work:** |  |
| **Registration number:** |  |
| **Practice stamp:**(if applicable) |  |

School-appointed AARA Assessor signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_