Supporting Documentation to Register for Support – Pregnancy & Postnatal
(access to adjustments is managed by the Inclusion and Disability Services Office)

This form is to be completed by a medical or other accredited health professional to enable the student to access reasonable adjustments for support. Depending on the inherent requirements of a student's course, recommended adjustments may not always able to be implemented. When completed, please forward this form to the student or return by email to Inclusion and Disability Services: disability.services@sydney.edu.au

Important: Personal information about students is protected under the Privacy and Personal Information Protection Act 1988 (NSW), the Health Records and Information Privacy Act 2002 (NSW) and the University of Sydney Privacy Policy and Procedures (available at http://sydney.edu.au/arms/privacy/).

1. Student details and authority

SID: _____ Full Name _____

I hereby consent to relevant information being provided by my medical/health practitioner and agree that they may provide verification of this certificate if requested by The University of Sydney.

Student's Signature: _____ Date: _____

2. Practitioner's assessment

I had a consultation with the above student on _____/_____/_____ and can confirm that they are pregnant/have recently given birth. Due to contraindications of pregnancy, pregnancy and/or post-natal complications, this student may require reasonable adjustments to manage specific course requirements. (Please list the symptoms/difficulties being experienced below and tick the areas in which support will be required. Please provide more detail on page 2. If the student is undertaking a course requiring a Q Fever vaccination, please advise whether the alternative Routine Prevention Activities listed in the NSW Health Q Fever Control Guideline are appropriate to mitigate the risk of contracting Q Fever and if any additional measures need to be implemented, taking into account the specific contraindication.)

☐ Assignments ☐ Examinations ☐ Classroom Support ☐ Placements/Clinicals ☐ Accessibility ☐ Other

3. Practitioner's details

Practitioner's name: _____

Contact number: _____

Provider / Registration No.: _____

Medical/Health
Practitioner's stamp

I declare that I am not a family member and do not have a close or personal relationship with this student. I authorise The University of Sydney to contact me or my office to confirm authenticity of this document.

Practitioner's Signature: _____ Date: _____

* Please complete the following 'Recommendations for Adjustments' page, and if required, the Safety Plan page and the Placements page.

Inclusion and Disability Services
Student Support Services
Level 5, Jane Foss Russell Building G02

T +61 2 8627 8422
F +61 2 8627 8482
E disability.services@sydney.edu.au

ABN 15 211 513 464
CRICOS 00026A

The University of Sydney

sydney.edu.au/disability

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Recommendations for Adjustments/Support	
Please make recommendations for assistance required.	
Accessibility (e.g. physical environments; materials; etc.)	□ N/A
Lectures	□ N/A
Classroom Support (tutorials; labs; seminars; etc.)	□ N/A
Assignments (e.g. individual; group; presentations etc.)	□ N/A
Examinations (e.g. timed tasks; practical tests etc.)	□ N/A
Placements/Field Work NB: Additional documentation may be required.	**Please complete page 4 of this form if placement adjustments are required as part of the student's degree**
Assistive Technology (adaptive software or hardware)	□ N/A
Other	□ N/A

Safety Plan
Does this student require a medical or mental health safety plan? □ Yes □ No
If yes, please fill out the safety plan on the next page or include a copy of an existing plan.

Safety Plan

This document is to be completed by a medical or other appropriate health professional if a student has a medical or mental health condition which may require a safety plan. This information will be kept on the student's file at Inclusion and Disability Services so that we have this information should we become aware that the student is in crisis. This form is also available at sydney.edu.au/disability

Please refer to privacy information on the front of this form. The information provided in this safety plan may be shared with external placement providers if required to meet WHS requirements.

On completion of this form please forward to the student, together with the supporting documentation above.

Student Details

Full Name	
Student ID	

Warning Signs (ie. signs and symptoms, behaviour) that a medical or psychiatric crisis may be developing

1.
2.
3.
4.
5.
6.

Student's self-management or prophylactic measures to avert a crisis

1.
2.
3.
4.
5.
6.

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:

Details of local area health service crisis team (if relevant):

Signature of medical or health professional providing safety plan

Name:

Signature: Date:

Recommendations for Placement Adjustments/Support

This section of the form should be completed if the student is required to undertake placements or field work as part of their degree and may require additional support or adjustments. Please make recommendations for adjustments required considering the impact of the student's condition and where possible provide reasoning.

Due to the inherent requirements related to a student's course, all recommendations will need to be reviewed and assessed by an Inclusion and Disability Services Officer and may not be guaranteed when determining reasonable adjustments. Students are encouraged to review the Inherent Requirements for their course of study: https://www.sydney.edu.au/students/student-responsibilities/inherent-requirements.html

Student Details

Full Name	
Student ID	
Location	□ N/A
Attendance and hours	□ N/A
Accessibility (i.e. accessible workplace/workspace, specialised equipment/technology, parking)	□ N/A
Specific Supervision Needs	□ N/A
Physical restrictions (i.e. lifting capacity, restrictions around postural control or physical activities)	□ N/A
Other	

Signature of medical or health professional

Name:	
Signature:	**Date:**