CONFIDENTIAL

STUDENT INFORMATION SHEET

We wish to work with you in your efforts toward a positive educational experience while attending our college. To do this, we need you to tell us what your particular needs are and to release information that will allow us to communicate with the appropriate personnel. Please complete the following:

DATE___________________________

NAME____

STUDENT ID NUMBER _______________________ BIRTHDATE _______________

PERMANENT ADDRESS ____

____

TELEPHONE __________________

ENROLLMENT STATUS:
_____NEW
_____CONTINUING
_____TRANSFER
_____RETURNING

DISABILITY STATUS:
_____ TEMPORARY: ___________
(STATE HOW LONG)
_____ PERMANENT

DISABILITY:
(CHECK ALL THAT APPLY)
_____VISION
_____HEARING
_____MOBILITY/ORTHOPEDIC
_____LEARNING
_____ PSYCHIATRIC
_____CHRONIC HEALTH
_____OTHER:________________
(INDICATE TYPE)

SPECIALIZED SUPPORT SERVICES:
(CHECK ALL THAT APPLY)
______DIVISION OF VOCATIONAL REHABILITATION (DVR)
______ RECORDING FOR THE BLIND AND DYSLEXIC
______ OTHER: _________________
(INDICATE AGENCY)

BREIFLY DESCRIBE YOUR DISABILITY/DISABILITIES AND HOW IT AFFECTS YOUR ACADEMIC PERFORMANCE.

____

____

____

STUDENT NAME: ________________

RELEASE OF INFORMATION

(THIS CONSENT IS REQUIRED BY THE FAMILY EDUCATION RIGHTS AND PRIVACY ACT OF 1974)

I hereby give my permission to share information with the following persons/agencies:

____ALL AGENCIES AND/OR PERSONS WITH A LEGITIMATE EDUCATIONAL NEED TO KNOW.

(Or, check specific groups below with whom we may share information)

____Appropriate faculty
Please list: ____

____

____Instructional Support Staff (e.g., Library, Learning Center, etc.)

____Parents (Names) ____

____Previous/future education institutions

____ Medical/counseling facilities

____ Recordings for the Blind and Dyslexic/Library for the Blind

____ Division of Vocational Rehabilitation (DVR)

____ Other: ____

____

I understand that I must have documentation on file to be eligible for services as a student with a disability. I have a responsibility to identify myself as a person with a disability on the appropriate form designated by this college, and in the case of Federal audit, my records may be opened. Unless otherwise notified, this release of information will expire following my exit from this college.

____ ________________

Student Signature Date

STUDENT REQUEST FOR ACCOMMODATIONS

NAME: ____ DATE: __________________

STUDENT ID NUMBER: _________________________ PHONE: _________________

I have provided documentation of my disability. Accordingly, I need the following accommodations. I will provide notification of the needs for the following in a timely manner. I understand that failure to comply with the established policies and procedures may result in the suspension of the requested service.

TESTING ACCOMMODATIONS:
(CHECK ALL THAT APPLY)

____ EXTENDED TIME ON TESTS
____ DISTRACTION REDUCED ENVIRONMENT
____ ALTERNATE FORMATS
_____ORAL
_____ BRAILLE
_____ ENLARGED PRINT
____ READER
____ SCRIBE
____ OTHER ____

CLASS ROOM ACCOMMODATIONS:
(CHECK ALL THAT APPLY)

____ NOTE TAKER
____ READER
____ SCRIBE
____ SIGN LANGUAGE INTERPRTER
____ TAPE RECORDER
____ ALTERNATIVE TEXT BOOKS
TYPE ____
____ SPECIAL SEATING
____ OTHER ____

____

____

______________________________________ ______________________
Student Signature Date