Accessibility Services Student Intake Form

STUDENT NAME: (Top portion must be completed in its entirety).

(Last Name)                                                                                                 (First Name)                                                                                             (Middle Name)

Mailing Address: __________________________________________________________________________________________

City: ___________________________ State: ___________________________ Zip Code: ___________________________

Cell Phone: ________________________________________________________________________________________________

E-mail Address: ____________________________________________________________________________________________

DISABILITY INFORMATION:

☐ LD/ADD/ADHD ☐ Visual/Impairment ☐ Temporary Injury
☐ Hearing Impairment ☐ Traumatic Brain Injury ☐ Other: ___________________________
☐ Physical ☐ Psychological Disability ☐ Learning Disability
☐ Medical

Please describe your disability and how it affects your academic activities and daily living:

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Type of accommodation requested:

Please describe any secondary disability or additional information that may help us assist you including type of accommodations received in the past.

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

List any medications: ________________________________________________________________

ADDITIONAL SUPPORT AGENCIES:

☐ BVR ☐ Workman's Compensation ☐ None
☐ Veterans Administration ☐ Other ___________________________

If you checked one of the above, what is your counselor's name? _____________________________
When do you plan to enroll at Trinity College of Nursing & Health Sciences? __________________________

Please read the following statement before signing and returning this form. If you have any questions, please contact Hilary Henke at (309) 779-7720.

I understand that in addition to completing this form, I need to provide documentation to develop an accommodation plan to receive services. As a participant in the Accessibility Services program at Trinity College of Nursing & Health Sciences, I give permission to share information with other college departments and faculty that will support and enhance the services I am requesting through this program.

Student Signature: __________________________ Date: __________________________

Please return this form to the following:

Mail: Hilary Henke
Trinity College of Nursing & Health Sciences
2122 25th Avenue
Rock Island, IL 61201-5317

FAX: 309-779-7748
DROP OFF: Student Services Office

Consent to Release Information

While the Director of Student Services and External Relations will not release specific information about a disability, he/she will verify that the appropriate disability documentation is on file and share with the faculty/staff the reasonable accommodations.

I authorize the Director of Student Services and External Relations to share, as needed, more specific detailed information regarding my disability with Trinity College of Nursing & Health Sciences personnel who have a legitimate need to know in order to provide appropriate accommodations.

This may include: Faculty, Academic Advisors, Dean of Nursing & Health Sciences, Program Coordinators, College Administrators, or others whose response to my request for accommodations may require knowledge regarding my disability.

Initial: __________________________

I authorize the Director of Student Services and External Relations to discuss my disability, accommodations, and general progress with

Parents or Guardians (list names): __________________________________________

Initial: __________________________

Community Agency/Persons: __________________________________________

Initial: __________________________
Accessibility Services Auxilary Aides & Academic Accommodations Documentation Form

STUDENT NAME: ____________________________________________________________

ACADEMIC PROGRAM: ____________________________________________________
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Student Signature: _________________________________________________________ Date: ______________

Director of Student Services Signature: ________________________________________ Date: ______________