Accessibility Service 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
- ☐ Hearing Impairment
- ☐ Physical
- ☐ Medical
- ☐ Visual/Impairment
- ☐ Traumatic Brain Injury
- ☐ Psychological Disability
- ☐ Learning Disability
- ☐ Temporary Injury
- ☐ Other: _____

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
- ☐ Veterans Administration
- ☐ Workman's Compensation
- ☐ Other _____
- ☐ None

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 Dr. Kim Perry at (309) 779-7712.

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: _____

Consent to Release Information

While the ADA Coordinator will not release specific information abo ut 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 ADA Coordinator 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 ADA Coordinator to discuss my disability, accommodations, and general progress with:

Parents or Guardians (list names): _____

Initial: _____

Community Agency/Persons: _____

Initial: _____

Documentation from a licensed healthcare provider should meet the following criteria:

1. Letter printed on letterhead that describes the diagnosis affecting major life activities, symptoms, limited functional abilities in an educational setting, and recommendations regarding effective academic accommodations to equalize student's educational opportunities
2. Credentials and contact information of the licensed professional

Please return this form and documentation from a licensed healthcare provider to the following:

Mail: **Dr. Kim Perry | ADA Coordinator**
Trinity College of Nursing & Health Sciences
2122 25th Avenue
Rock Island, IL 61201-5317

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