

**Disability Support Program for Students**

**Application for Services/Intake Form**

**STUDENT INFORMATION:**

Name:

Address: City:

Date of Birth:

State:

 Zip:

Home Phone:

Cell Phone:

Email address:

Is it ok to call/text?

Yes

No

Disability:

**EMERGENCY CONTACT:**

Name:

Relationship:

:

Address

State:

 Zip:

Home Phone:

Cell Phone:

**OTHER INFORMATION:**

List all medications you are taking:

List all allergies, if any, including

Could an emergency situation occur due to your disability?

If yes, are there any special procedures that should be followed in case of

Yes

No

Should a medical alert be provided to instructors and staff

to inform them about a medical condition?

Yes

No

Are you a client of the Department of Rehabilitation?

If yes, what is the name of your Department of Rehabilitation Counselor and in what city is the office

Yes

No

If applicable, what is the name and address of the medical provider who has diagnosed or

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Yes

No

Have you received disability support services at any other college(s)?

If yes, please give the college name(s) and a description of the accommodations received.

Did you ever receive support services or resource classes in elementary, middle,

or high school?

If yes, please describe what services or classes you received.

Yes

No

How did you hear about our disability supportprogram? Self-referral Referred by someone else

Referred by: (Name and

position/relationship of person who referred you.)

What barriers to the educational process do you face as the result of disability? (Examples: limited mobility

What services are you hoping to receive from our disability support program to assist you in accessing your

Are you a former foster youth? (optional)

Yes

No

Are you a veteran? (optional)

Yes

No

By signing below, I certify that the information above is true and correct to the best of my knowledge

Signature:

Date:

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