

THIS FORM IS CONFIDENTIAL

- ⇒ Please fill out this form completely, front and back.
- ⇒ Please type information or print (not cursive) if handwritten.

STUDENT INFORMATION

First Name		Middle Initial	Last Name	
Today's Date (mm/dd/yy)		Cascadia College Student ID # (SID)		Date of Birth (mm/dd/yyyy)
What is the current quarter <u>OR</u> the first quarter in which you are requesting accommodations? <input type="checkbox"/> Fall <input type="checkbox"/> Winter Year _____ <input type="checkbox"/> Spring <input type="checkbox"/> Summer			If you are already/have previously been a Cascadia College student, what was the first quarter you were enrolled? <input type="checkbox"/> Fall <input type="checkbox"/> Winter Year _____ <input type="checkbox"/> Spring <input type="checkbox"/> Summer	
Home Address			City	State
Phone Number		Email Address		
Zip Code				

Please indicate your disability/ies or health condition(s); mark all that apply & include diagnosis date:

Sensory	Learning	Speech or Language
<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Deaf <input type="checkbox"/> Vision Loss <input type="checkbox"/> Blind <input type="checkbox"/> Sensory Processing Issues <input type="checkbox"/> Other _____	<input type="checkbox"/> Specific Learning Disability _____ <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Other _____	<input type="checkbox"/> Apraxia <input type="checkbox"/> Dysarthria <input type="checkbox"/> Aphasia <input type="checkbox"/> Other _____
Psychological/Emotional	Mobility	Neurological
<input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Mood Disorder <input type="checkbox"/> Post-Traumatic Stress Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other _____	<input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Paraplegic <input type="checkbox"/> Quadriplegic <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Other _____	<input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Tourette's <input type="checkbox"/> Other _____
Chronic or Acute Conditions		Other, please describe:
<input type="checkbox"/> Cancer <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Immune disorder <input type="checkbox"/> Environmental illness <input type="checkbox"/> Crohn's Disease		
<input type="checkbox"/> Diabetes <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Cardiac/Cardiovascular <input type="checkbox"/> Asthma or Pulmonary <input type="checkbox"/> Other _____		

Continue on back

Please mark all applicable areas that are affected by your disability/ies or health condition:

<input type="checkbox"/> Reading	<input type="checkbox"/> Attention/Concentration	<input type="checkbox"/> Activity restriction (e.g. heavy lifting, walking on uneven surfaces): _____
<input type="checkbox"/> Writing papers	<input type="checkbox"/> Organization	_____
<input type="checkbox"/> Handwriting/Fine motor control	<input type="checkbox"/> Time management	<input type="checkbox"/> Environmental issues (e.g. temperature, lighting, sounds): _____
<input type="checkbox"/> Computer keyboarding	<input type="checkbox"/> Emotional/Feelings management	_____
<input type="checkbox"/> Use of computer screen	<input type="checkbox"/> Class participation	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Information processing	<input type="checkbox"/> Group participation	_____
<input type="checkbox"/> Memory/Information recall	<input type="checkbox"/> Social interaction	_____
<input type="checkbox"/> Reasoning	<input type="checkbox"/> Energy levels/Endurance	_____
<input type="checkbox"/> Math/Numerical logic	<input type="checkbox"/> Sensory sensitivity	_____
	<input type="checkbox"/> Chemical sensitivity or allergy	_____

What challenges or barriers do you face in the classroom?

Accommodations Overview

Have you received reasonable accommodations at any other college/university in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, what is the name of the college/university?
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What classroom accommodations/academic adjustments have you had in the past, if any?

General Questions & Other Information

How did you find out about Disability Support Services?

Are you currently taking any medications that we should be aware of? Are there any side effects?

Mark all that apply to you, if any: <input type="checkbox"/> Veteran <input type="checkbox"/> Running Start student <input type="checkbox"/> Adult Basic Education (ABE) student <input type="checkbox"/> English Language Program (ELP) student	<input type="checkbox"/> Client of the Division of Vocational Rehabilitation; the Department of Social & Health Services (DSHS); Labor and Industries; or WorkSource	Do you wish to be placed on the Emergency Assistance List in case of a campus emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please initial below to release permission for DSS to place your name, brief nature of your disability (i.e. mobility limitations, seizures, etc.), quarterly class schedule, and contact information on a list that is provided to security so that, in the event of a campus emergency, staff will do what they can to assist you appropriately. Student Initials _____
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- I understand that students who receive reasonable accommodations for disability must meet essential academic and conduct standards. Cascadia College’s academic and conduct standards can be found online.
- I am aware that my rights and responsibilities are outlined in the DSS Handbook on Cascadia’s website.
- I understand that it is my responsibility to discuss questions or concerns I have regarding accommodations.
- I give DSS permission to discuss this information, my accommodations, and other relevant information with faculty, advisors, administrators, and/or staff to further my educational goals. I understand DSS will enter my disability status in Student Success Services records for confidential statistical purposes.

Student signature _____ **Date** _____