Student Application / Intake Form

(Please **PRINT**)

OFFICE USE ONLY
Date Received _____
Staff Initials _____
Enrollment Status

Last Name: _____ First Name: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Student ID #:_____ Date of Birth: _____

☐ Male ☐ Female ☐ Decline to State

Email: _____

Primary Language: ☐ English ☐ Spanish ☐ ASL ☐ Other: _____

Interpreter Requested? _____ Referred By: _____

1. Are you currently enrolled at COS? ☐ Yes ☐ No
   Which campus would you prefer to receive Access & Ability Center Services:
   ☐ Visalia ☐ Hanford ☐ Tulare
2. Have you ever received services from this Access & Ability Center in the past?
   ☐ Yes ☐ No If yes, what year: _____
3. What is the nature of your qualifying condition(s)? (Please select all that currently apply.)
   - ☐ Attention-Deficit Hyperactivity Disorder (ADHD)
   - ☐ Autism Spectrum
   - ☐ Blind and Low Vision (do not check if vision is corrected by glasses/contacts)
   - ☐ Brain Injury (stroke, head trauma, aneurysm, hydrocephalus, etc.)
   - ☐ Deaf and Hard of Hearing (Deaf, partial hearing loss, etc.)
   - ☐ Intellectual Disability (Developmentally Delayed Learner, Down's syndrome etc.)
   - ☐ Learning Disability (difficulty with math, reading, writing, test anxiety, etc.)
   - ☐ Mental Health Condition (generalized anxiety, panic, bipolar, depression, schizophrenia, PTSD, etc.)
   - ☐ Physical Disability (arthritis, back/leg/arm injury, carpal tunnel syndrome, fibromyalgia, etc.)
   - ☐ Other (asthma, diabetes, migraines, seizures, speech, fibromyalgia, thyroid or heart condition, etc.)

   If you do not see your condition listed above, please list the type of condition(s) you have here:
   _____
4. Are you currently taking any prescription medications? ☐ Yes ☐ No
   If yes, please list prescription names: _____

_____

Please complete other side of form ⟹

ALTERNATE FORMATS:
This publication can be made available in an alternative format.
Please contact the Access & Ability Center at 559-730-3805.

5. Have you ever had a seizure? ☐ Yes ☐ No If yes, when did this last occur? _____

6. Did you receive any of the following services in high school? (Check all that pertain to you.)

☐ Resource Specialist (RSP) ☐ Special Education ☐ IEP ☐ 504 Plan ☐ Special Day Class

If yes, what year did you last attend this high school? _____

7. Have you been assessed for a learning assessment at a college? ☐ Yes ☐ No If yes, what year? _____

Name of college where you were assessed: _____

8. Are you a client of any of the following agencies?

☐ Department of Rehabilitation (DOR) ☐ Central Valley Regional Center (CVRC)

☐ WorkAbility ☐ Other: _____

If yes, what is your counselor's name? _____

9. Do you feel your condition affects any of the following?

☐ Taking notes in class

☐ Completing written assignments

☐ Seeing or understanding visually presented classroom materials

☐ Seeing or understanding texts, handouts, and other printed material

☐ Hearing or understanding lecture, student discussion, and related oral presentations

☐ Finishing tests in a timely manner

☐ Understanding test questions

☐ Using certain college facilities, equipment, and materials

☐ Self-advocating with college instructors, and other personnel

☐ Interacting with Department of Rehabilitation and other resources in the community

I acknowledge that it is my responsibility to provide appropriate verification of my condition(s).

_____

Student Signature Date