



# INTAKE

Office for Special Needs Services CC 234

NAME \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Email: \_\_\_\_\_ SN \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Referred By \_\_\_\_\_

Graduated from High School \_\_\_\_\_ Year \_\_\_\_\_

College Major \_\_\_\_\_

## DISABILITY INFORMATION

Check all that apply and list date of diagnosis (month/year):

- Attention Deficit Disorder (ADD or ADHD) \_\_\_\_\_
- Autism Spectrum Disorder \_\_\_\_\_
- Chronic Health Condition \_\_\_\_\_
- Cognitive Disability \_\_\_\_\_
- Deaf/Hearing Loss \_\_\_\_\_
- Learning Disability \_\_\_\_\_
- Neurological Condition \_\_\_\_\_
- Physical Disability \_\_\_\_\_
- Psychological Disability \_\_\_\_\_
- Traumatic Brain Injury \_\_\_\_\_
- Visual Impairment \_\_\_\_\_
- Other \_\_\_\_\_

Are you taking any medications?      YES                      NO

Please list: \_\_\_\_\_

Side Effects: \_\_\_\_\_

Are you registered with BVR or another sponsoring agency?      YES                      NO

Are you presently seeing a licensed counselor, psychiatrist, or other medical professional?

YES                      NO

**In your own words, describe your disability and how it affects your ability to function on a college campus.**

---

---

---

---

---

---

---

**What accommodations (types of help) have you received in the past (high school, different college)?  
What did you find most helpful?**

---

---

---

**What accommodations are you requesting at Lorain County Community College?**

---

---

---

**By signing below you agree to the following:**

I understand that submitting this form does not automatically qualify me for accommodations and/or services. I understand that I will not be eligible to receive verified accommodations until all documentation is provided and the registration process is complete.

**Student Signature** \_\_\_\_\_ **Date** \_\_\_\_\_