EDGEWOOD COLLEGE

1000 Edgewood College Drive • Madison, WI 53711 • Tel: 606-663-2281 • Fax: 608-663-2278

Personal Information

Last Name: _____ First Name: _____

Middle Name: _____ Preferred Name: _____ Student ID #: _____

Date of Birth: _____ Age: _____ Gender: ☐Female ☐Male Race/Ethnicity_____

Edgewood Email Address: _____@edgewood.edu Alt. Email Address: _____

Home Address: _____
Street City

_____
Apt. # State Zip Code

Home Phone #: _____ Cell Phone #: _____ Work #: _____

Marital Status: _____ Citizenship: _____ Veteran: ☐Yes ☐No

Academic Information

Origin: ☐Incoming freshman ☐Currently enrolled ☐Cutting Edge ☐RAAD ☐ ELL/International
☐Exchange student ☐Transfer student ☐Exchange/Transfer School: _____

Enrollment Status: ☐Full time ☐Part time

College Year: ☐Freshman ☐Sophomore ☐Junior ☐Senior ☐Post Bac. ☐Grad Student

First semester at Edgewood: _____ Year: _____ Expected Graduation Year: _____ Year: _____
Fall / Spring Fall / Spring

Are you a Resident? ☐Yes ☐No Are you a commuter? ☐Yes ☐No

If you live on campus, name of Residence Hall: _____ Floor #: _____ Room #: _____

Specify Course Major at Edgewood College if known: _____

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Previous Schools Attended

Previous School(s) Attended	Dates Attended (From – To)	Approved Disability Accommodations Used in School

Disability Information

Specify your disability type (Check all that apply):

☐Physical
Specify: _____

☐Psychological
Specify: _____

Chronic Medical Condition
Specify: _____

☐Deaf
☐Hard of Hearing
☐Blind
☐Low Vision
☐Addictive Disorder
☐Traumatic Brain Injury
☐Autism Spectrum Disorder
☐Learning Disability
☐Attention Deficit/Hyperactive Disorder (AD/HD)
☐Other: _____

Academic Accommodations

How does your disability impact you academically?

_____

_____

_____

How does your disability affect you in your everyday life and daily activities?

_____

_____

_____

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To be completed ONLY by Individuals with a Hearing Disability or who are Deaf:

Date of diagnosis: _____

Do you wear hearing aids or cochlear implants? ☐Yes ☐No

If yes, check all that apply:

☐Behind-the-ear hearing aids

Do you have Direct Audio Input (DAI)? ☐Yes ☐No

☐In-the-ear hearing aids

☐In-the-canal hearing aids

☐Cochlear implant – ear level processor

☐Cochlear implant – body worn processor

☐My device has telecoils

☐Have you used a neck loop with telecoils? ☐Yes ☐ No

☐My device has an M-T (microphone telecoil switch)

Do you or have you used an FM system/assistive listening device in the past? ☐Yes ☐No

If yes, please specify type (brand, model): _____

If yes, how does/did sound get to your ear?

☐Neck loop ☐Ear phone (in the ear)

☐Cochlear implant ☐Headphone (over the ear)

Please describe how you use a telephone:

☐I use an amplified telephone ☐I use a "smart phone" for emailing and texting

☐I use TTY only ☐Other: _____

What types of other auxiliary aids have you used, if any? _____

Do you use captioned media? ☐Yes ☐No

What means of expression and receptive communication do you use? (Check all that apply):

☐Oral Communication ☐Speech Reading ☐American Sign Language ☐Other please specify: _____

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To be completed ONLY by Individuals with a Chronic Health Condition, Physical or other Mobility disability:

Which, if any, of the following mobility aids do you use?

☐Prosthesis (specify): _____ ☐Braces ☐Crutches ☐Cane

☐Manual Wheelchair ☐Motorized wheelchair/scooter ☐Other (specify): _____

Do you experience any of the following? (Check all that apply)

☐I have difficult standing for long periods of time ☐I have difficulty writing ☐I tire easily when I walk distances

☐I have difficulty walking up/down stairs ☐I utilize assistive technology. Please specify: _____

☐I have academic difficulties. Please describe: _____

To be completed ONLY by Individuals who are Blind or have a Visual Disability:

Visual Acuity (if applicable): _____ Left Eye: _____ Right Eye: _____

Degree of blindness: ☐Total ☐Light Perception ☐Form Perception

Travel Aids: ☐Cane ☐Service Animal ☐Other: _____

Do you use Assistive Technology? Specify type(s):

_____

_____

_____

Do you use alternative format reading materials? ☐Yes ☐No

☐**Large Print**

Specify font size (e.g. pt. 22 bold) _____ Specify font type (e.g. Arial) _____

☐**Electronic Format**

Specify file type (e.g. Word, audio file, pdf etc.): _____

☐**Braille**

Disability Documentation

Please provide information about the documentation of your disability you will be submitting to our office:

Name of Clinician/provider providing Documentation: _____

Date of Documentation (month/year): _____

Required Documentation:

☐Learning Disability ☐ ADD/ADHD Brown Rating Scale/Score ☐Psycho-Educational Evaluation

☐Neuropsychological Evaluation

Supporting Documents:

☐Letter from previous school confirming approved disability accommodations

☐Letter from Medical Provider

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Academic Accommodations and Services

Please specify what accommodation you are requesting. Student Accessibility and Disability Services will consider your request in light of your disability as described in your documentation, and other information provided to our staff, as well as the requirement of your specific academic program.

Testing Accommodations:

☐1.5X Time for exams and quizzes ☐2X Time for exams and quizzes ☐Quiet proctored environment

☐Use of a calculator ☐Recorded test/reader ☐Computer (e.g. word processor, spell check, excel etc.)

☐No Scantron ☐Scribe/Voice Rec. ☐Enlarged Prints

☐Stop the clock 'rest breaks' (indicate rest time needed per hour: _____ minute per hour of exam time)

☐Specify accommodations (if different from above): _____

Other Accommodations:

☐Peer-note-taking ☐Housing (Accessible) ☐Housing (Single) ☐CART/Interpreting

☐Lab Assistant ☐ Record Lecture ☐Course sub. (FL) ☐Flexible Attendance

☐Priority Registration ☐Textbook in alternate format (E.g. 6 weeks turnaround)

☐Other, specify: _____

Communication/Technology Accommodations:

Use of Assistive Technology: ☐Kurzweil ☐Dragon Naturally Speaking ☐Zoomtext

☐ Other, Specify: _____

In case of emergency, please provide names of two people whom may we contact on your behalf.

First Contact Person:

Name: _____

Phone Number: _____ Relationship: _____

Student's signature: _____ Date: _____

Second Contact Person:

Name: _____

Phone Number: _____ Relationship: _____

Student's signature: _____ Date: _____

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Confidentiality and Information Release

In order for you to make the best out of this service, there are several issues I would like to explain before we begin our work together. Confidentiality is one of the most important elements in human service work. Within certain legally defined limits, all of our communications, as well as any information learned about you from another source during the time you are a participant in this service, are private and will not be released to another person or agency without your written permission. There are, however, some exceptions to this policy. Please read them carefully.

The most important exceptions are those in which there might be some danger to you or another person. If, in my judgment, I believe that you pose a threat to yourself, I am required by law to take professional action to ensure your safety. Similarly, if I believe that you might harm someone else, I am required to warn that person or to notify authorities. Although I am not legally obligated to inform you before breaching confidentiality in these situations, I will make a reasonable effort to discuss this with you, if it seems appropriate to do so.

Another exception to the rule concerns our weekly staff meetings. During these meetings, which consist of the directors, student support staff, and tutors, cases will be discussed. The purpose of these meetings is to share ideas and expertise in order to provide students with the best possible services.

One final point about confidentiality: Cases are often discussed with faculty on an as needed basis. Most of these discussions will occur with your consent. However, there may be times when appropriate student accommodations are dependent on the timely provision of information to necessary faculty members. At these times I will use my best judgment as to what to disclose and to whom.

Thank you for reading this. Please take the time to ask me any questions that you might have.

I_____, authorize Student Accessibility and Disability Services staff to have access to any and all academic records as needed to assist me in planning schedules and evaluating academic progress.

I _____, give permission Student Accessibility and Disability Services staff to divulge whatever information they deem necessary to other professional members at Edgewood College Community, concerning academic, advising, counseling, testing, and/or other relevant matters.

I _____, give permission to Student Accessibility and Disability Services staff at Edgewood College to contact relevant external service providers (medical doctors, psychologists, audiologist, psychiatrists, etc.) who have provided information concerning my disability, in order to obtain information needed to determine appropriate and effective accommodations and services.

I _____, give permission to Student Accessibility and Disability Services staff to communicate with external agencies, faculty members, staff, and relatives concerning any academic, personal, medical, or psychological issues arising during my studies at Edgewood College.

Client Acknowledgement

My signature below indicates that I have (or had read to me) this document. I had all of my questions answered satisfactorily and choose to accept these terms.

Signature of Student: _____ Date: _____

Signature of Director _____ Date: _____