

Office of Services for Students with Disabilities
STUDENT INTAKE FORM

All information provided to the Office of Services for Students with Disabilities is confidential and will only be shared with your permission to other individuals, for the purpose of providing approved accommodations.

Name: _____ Date: _____

Student ID # _____ Birth Date _____

Perm Address _____ Perm Phone _____

Local Address _____ Local Phone _____

Email _____ Cell Phone _____

Major _____ Anticipated Graduation Date: _____

Did you transfer from another college/school? YES NO

If yes, please indicate name of institution: _____

Sponsored By: VESID (OVR) CBVH

Other (please specify) _____

Counselor: _____ Phone # _____

Please identify any disorder(s) or impairment(s) that you have been diagnosed with:

Are you taking medications?

Yes

No

If yes, please list medications _____

Describe adverse effects, if any: _____

Please identify any other conditions(s) affecting school that you would like to discuss:

Current Treating Specialist: _____

Contact Information: _____

Services/Accommodations Requested:

FUNCTIONAL LIMITATIONS: Please check any of the major life activities listed below that you believe are affected as a result of your diagnosed condition. Please indicate the level of limitation you believe you experience as a result of the condition.

1= Unable to Determine 2 = Mild 3 = Substantial

1	2	3		1	2	3	
			Caring for Oneself				Learning
			Talking				• Reading
			Hearing				• Writing/Spelling
			Breathing				• Calculating
			Seeing				• Memorizing
			Walking/Standing				• Concentrating
			Lifting/Carrying				• Listening
			Sitting				Other:
			Manual Tasks				
			Eating				
			Working				

OFFICE USE ONLY

Pending Receipt of Documentation:

Documentation Received/Reviewed on: _____

Approved Accommodations: _____

The Office of Services for Students with Disabilities
 Foy Hall 109
 515 Loudon Road
 Loudonville, NY 12211
 518-783-4239