Trinity College of Nursing & Health Sciences
UnityPoint Health

Accessibility Service Student Intake Form

STUDENT NAME: (Top portion must be completed in its entirety).

_____
(Last Name) (First Name) (Middle Name)

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____

E-mail Address: _____

DISABILITY INFORMATION:

- ☐ LD/ADD/ADHD
- ☐ Hearing Impairment
- ☐ Physical
- ☐ Medical
- ☐ Visual/Impairment
- ☐ Traumatic Brain Injury
- ☐ Psychological Disability
- ☐ Learning Disability
- ☐ Temporary Injury
- ☐ Other: _____

Please describe your disability and how it affects your **academic activities** and **daily living:**

_____

_____

_____

_____

_____

Type of accommodation requested: _____
Please describe any **secondary disability** or **additional information** that may help us assist you including type of accommodations received in the past.

_____

_____

_____

List any medications: _____

ADDITIONAL SUPPORT AGENCIES:

- ☐ BVR
- ☐ Veterans Administration
- ☐ Workman's Compensation
- ☐ Other _____
- ☐ None

If you checked one of the above, what is your counselor's name? _____

When do you plan to enroll at Trinity College of Nursing & Health Sciences? _____

Please read the following statement before signing and returning this form. If you have any questions, please contact Dr. Kim Perry at (309) 779-7712.

I understand that in addition to completing this form, I need to provide documentation to develop an accommodation plan to receive services. As a participant in the Accessibility Services program at Trinity College of Nursing & Health Sciences, I give permission to share information with other college departments and faculty that will support and enhance the services I am requesting through this program.

Student Signature: _____ Date: _____

Please return this form to the following:

Mail: **Dr. Kim Perry | ADA Coordinator**
Trinity College of Nursing & Health Sciences
2122 25th Avenue
Rock Island, IL 61201-5317

FAX: **309-779-7748**
DROP OFF: **Student Services Office**

Consent to Release Information

While the ADA Coordinator will not release specific information abo ut a disability, he/she will verify that the appropriate disability documentation is on file and share with the faculty/staff the reasonable accommodations.

I authorize the ADA Coordinator to share, as needed, more specific detailed information regarding my disability with Trinity College of Nursing & Health Sciences personnel who have a legitimate need to know in order to provide appropriate accommodations.

This may include: **Faculty, Academic Advisors, Dean of Nursing & Health Sciences, Program Coordinators, College Administrators**, or others whose response to my request for accommodations may require knowledge regarding my disability.

Initial: _____

I authorize the ADA Coordinator to discuss my disability, accommodations, and general progress with:

Parents or Guardians (list names): _____

Initial: _____

Community Agency/Persons: _____

Initial: _____

Accessibility Services Auxilary Aides & Academic Accommodations Documentation Form

STUDENT NAME:

ACADEMIC PROGRAM:

Student Signature: _____ Date: _____

ADA Coordinator : _____ Date: _____