

# Office for Students With Disabilities

## STUDENT INTAKE FORM

*(please print clearly)*

Name \_\_\_\_\_ Student ID# \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ Emergency Contact Name \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Emergency Phone Number \_\_\_\_\_

E-mail (if any) \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Please describe your disability(ies):** \_\_\_\_\_

\_\_\_\_\_

Were you born with your disability?  Yes  No

If no, what age were you when you developed your disability? \_\_\_\_\_

What limitations do you have as a result of your disability? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you a client of the California Department of Rehabilitation?  Yes  No

If yes, who is your counselor? \_\_\_\_\_

ANTELOPE VALLEY COLLEGE  
Office for Students With Disabilities

Student Contract

**PHILOSOPHY:** The Office for Students With Disabilities encourages students to be as independent and self-reliant as possible. We work closely with each student to assess their special needs and will only provide those support services and accommodations that directly address a student's functional limitations as a result of their disability.

**Support Services and Accommodations**

Support Services are based on the functional limitations resulting from your disability. Please be sure to follow the guidelines for each service you are eligible for.

Support services include: sign language interpreters, real-time captioning, readers, scribes, tape recording lectures, books on tape, accessible seating, test accommodations, notetakers, priority registration, equipment loan, handicapped parking and use of the High Tech Center. Other support services may be available if deemed appropriate, please contact OSD for more information.

**Student Responsibilities**

1. It is your responsibility to provide the OSD Office with written verification of your disability and resulting educational functional limitations.
2. You are responsible for making your special needs known to your instructors, as soon as possible, thereby making it possible for you to work out any special accommodations that might be necessary.
3. Further, you are responsible to notify the OSD staff as soon as possible, if you experience any difficulty in your classes.

If disputes arise surrounding support services or accommodations in the classroom, you should contact the OSD Office immediately.

*Section 504 and the Americans with Disabilities Act Compliance Officer: Vice President of Human Resources and Employee Relations.*

I have read and understand the above information.

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<b>Print Name</b>	<b>Signature</b>	<b>Date</b>
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BLUE – to student      WHITE – to student file



ANTELOPE VALLEY COLLEGE

DISABLED STUDENT VOTER REGISTRATION INFORMATION

In 1993 Congress passed the National Voter Registration Act, Public Law 103-31 (codified as 42 U.S.C 1973gg) (hereinafter NVRA), in order to expand opportunities for voter registration. In particular, the law requires states to give an individual the opportunity to register to vote when he or she register's a motor vehicle or applies for certain public benefits. In addition. NVRA provides that voter registration services be available at "all offices in the State that provide State-funded programs primarily engaged in providing services to persons with disabilities."

Therefore. Office for Students With Disabilities at Antelope Valley College will make available voter registration applications to all disabled students at AVC. Registration to vote, or a lack thereof, will in no way affect a persons ability to receive OSD services. In addition, OSD Staff will provide assistance for those persons who request help in filling out the Voter Registration Application.



NAME: \_\_\_\_\_

If you are not registered to vote where you live now, would you like to apply to register to vote here today? (Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this office).

I would like to register to vote (circle one): Yes      No

**IF YOU DO NOT CIRCLE EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.**

\*If you would like help in filling out the voter registration application, we will help you. The decision whether to seek or accept help is yours. You may fill out the application in private.

\*\*If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

Secretary of State  
Elections Division  
1500 11th Street  
Sacramento, CA 95814-9910

ANTELOPE VALLEY COLLEGE  
 OSD RELEASE OF INFORMATION  
 Office for Students With Disabilities

Name/Address of College	Name/Address of Treating Physician/Verifying Professional
Attn. OSD Director	
Antelope Valley College	
3041 West Avenue K	
Lancaster, CA 93536	

Name of Student: \_\_\_\_\_ \*Student ID#: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**OSD Release of Information:**

I, \_\_\_\_\_, authorize the release of information from \_\_\_\_\_ regarding my  
*(Name of Student)* *(Name of Treating Physician or Verifying Professional)*  
 disability(ies) \_\_\_\_\_ to Antelope Valley College. All information will be kept  
*(Identify disability(ies) )* *(Name of College/Attn. DSP&S Coordinator)*  
 confidential and maintained as a part of my records with the California Community College Office for Students With Disabilities (OSD) Office.  
 I authorize the release of information to include one or more of the following records identified below:

- Diagnosis of disability.
- Psychological testing and evaluation results.
- Vocational Rehabilitation Plan.
- Individual Education Plan (IEP)
- Detailed results of assessment, psychological, or medical testing that led to the diagnosis.
- Other:

**A photocopy of this document is as valid as the original.**

I further give permission for OSD staff to discuss my educational situation with other professionals who have a legitimate need to know.

**This authorization shall remain in effect until revoked in writing by the undersigned.**

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The Community College District uses the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by the Disabled Students Services Program. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. Portions of this information may be shared with the Chancellor's Office of the California Community Colleges or other state or federal agencies; however, disclosure to these parties is made in strict accordance with applicable statutes regarding confidentiality, including the Family Educational Rights and Privacy Act (20 U.S.C. 1232(g)). Pursuant to Section 7 of the Federal Privacy Act (Public Law 93-579; 5 U.S.C. § 552a, note), providing your social security number is voluntary. The information on this form is being collected pursuant to California Education Code Sections 67310-67312, and 84850; and California Code of Regulations, Title 5, Section 56000 et seq.

ANTELOPE VALLEY COLLEGE  
OSD DISABILITY VERIFICATION  
Office for Students With Disabilities

**THIS SECTION MUST BE COMPLETED BY THE STUDENT**

Name: \_\_\_\_\_ \*Student ID#: \_\_\_\_\_

Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

In order to receive disability-related services at Antelope Valley College a verification of disability must be provided. I request that the professional designated below complete this form.

Name of Licensed or Certified Professional: \_\_\_\_\_

Address: \_\_\_\_\_

FAX #: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

**THIS SECTION MUST BE COMPLETED BY THE LICENSED OR CERTIFIED PROFESSIONAL**

Please provide the following information, in full in order to help determine reasonable educational accommodations to support this student:

1. Diagnosis: \_\_\_\_\_
2. DSM IV Code and Severity (if applicable) \_\_\_\_\_
3. Please describe how this condition substantially limits major life activities: \_\_\_\_\_  
\_\_\_\_\_

4. Condition is:                       stable     prone to exacerbation
5. Duration of Disability:         Permanent/Chronic                       Temporary (estimated duration of disability) \_\_\_\_\_

Please return this form to:

- College – Antelope Valley College, Attn: OSD, 3041 W. Avenue K, Lancaster, CA 93536
- Student – See Address Above

I understand that the information provided by the verifying professional will become part of the student record, and may be released to the student upon their written request.

Verifying Professional Signature

Date

If the above information is completed by someone other than the professional who made the diagnosis, please provide the name and address of the person who made the diagnosis in the space provided below.

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