CALHOUN
COMMUNITY COLLEGE

ADA Release and Statement Form

Name: _____ C Number _____

Address: _____

Phone _____ Email address: _____

I understand that it is my responsibility as a student to communicate with the Student Disability Services/ADA office each semester and complete a new Request for Academic Adjustments and Modifications Form. I may submit my course schedule via email, postal service, or in person. Phone calls will not be permitted. Academic adjustments and modifications are not retroactive and therefore it is best to contact the office before classes begin each semester.

I authorize the Student Disability Services/ADA office to discuss/release the following forms or information to the following people (Please print full names and relationships):

_____

_____

_____

Information to be released:

___ Academic Adjustments Notification ___ Class Schedule

Student Signature: _____ Date: _____

Student Disability Services/ADA Office Staff Signature & Date: _____

Please note that assessment documentation has to be current.

PSYCHIATRIC DISABILITIES – **NO MORE THAN 1 YEAR**
ADHD, LEARNING, COGNITIVE, MOBILITY, SENSORY, SYSTEMIC, & TRAUMATIC BRAIN INJURY – **NO MORE THAN 3 YEARS OLD**

Please return form to Office of Disability Services
Post Office Box 2216 • Decatur, Alabama 35609-2216
Phone 256-306-2630 • Fax 256-260-2447

Impairment and Disability Assessment

******TO BE COMPLETED BY A DOCTOR, LICENSED COUNSELOR, OR MEDICAL PROFESSIONAL******

In order for Calhoun Community College to provide disability-related services, we need to establish this student has a qualifying disability. A disability is defined as an impairment substantially limiting a major life activity. This form is designed to help us make that assessment. Please respond to the following items:

Student name: _____ **Student date of birth:** _____

Name of Doctor/Licensed Counselor/Medical Professional:
_____

Facility name and address: _____

_____

Facility phone number: _____

Signature of Medical Professional: _____

Date: _____

I. Impairment Assessment

A. What is the diagnosis/impairment?

_____

B. When was the diagnosis originally made?

_____

C. Is the patient/student currently under your care?

_____

D. When did you last see the patient/student?

_____

E. Is the impairment temporary (<6 months) or persistent?

_____

Continues on back

II. Major Life Activities Assessment

******TO BE COMPLETED BY A DOCTOR, LICENSED COUNSELOR, OR MEDICAL PROFESSIONAL******

Please check any of the major life activities listed below that are affected as a result of the impairment. Please indicate the level of limitation.

1 – Negligible 2 = Moderate 3 = Substantial

	1	2	3
Caring for oneself			
Speaking			
Hearing			
Breathing			
Standing			
Working			
Eating			
Lifting			
Walking			
Seeing			

	1	2	3
Bending			
Performing manual tasks			
Sleeping			
Learning			
Reading			
Thinking			
Concentrating			
Communicating with others			
Other:			

What are the functional limitations resulting from the impairment's impact on major life activities identified in #2 above?

Based upon the major life activities affected by the impairment, are there any accommodations within the context of the community college environment that you can recommend for this student?

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Student with a Disability: Individual Postsecondary Plan

Name _____ C Number_____ Date of Birth _____

Mailing Address _____

Phone _____ (Cell) _____ (Home)

Emergency Contact (Name and phone number) _____

I am enrolled or plan to enroll in the _____ Program
Major Program of Study

What type of disability do you have?

___ (1) Traumatic Brain Injury
___ (2) Learning Disability
___ (3) Visual Impairment
___ Blind
___ (4) Hearing Impairment
___ Deaf
___ (5) Motor/Orthopedic Impairment
___ (6) Chronic Health Problems
___ (7) Speech Impairment
___ (8) Seizure Disorder
___ (10) Chemical Dependency
___ (11) Psychological Disorder
___ (13) AD/HD
___ (14) Pervasive Developmental Disorder:
___ Autism ___ Asperger's ___ Tourette's
___ Other (please specify):
_____

Please explain your disability and include a list of necessary medication

_____

_____

How does your disability affect you in a classroom?

_____

_____

As a result of your disability, do you use any type of equipment for everyday living ( )Yes ( )No
If you answered "yes", what type of equipment do you use? _____

Do you have the required medical or psychological documentation clarifying your disability?
( )Yes ( )No
Can you climb stairs? ( )Yes ( )No Do you require parking accommodations? ( )Yes ( )No

Continues on back

Did you receive accommodations at a previous high school or college? ( )Yes ( )No
If you answered "yes", where? _____

What type of accommodations did you receive? _____

_____

What type of academic adjustments and modifications would you like to receive? _____

_____

_____

Have you applied to the Division of Rehabilitation Services in your state of residence? ( )Yes ( )No

If you answered "yes", who is your counselor, and where did you apply? _____

_____

Are you registered with Recordings for the Blind & Dyslexic? ( ) Yes ( ) No

Have you applied for financial aid? ( ) Yes ( ) No

If yes, status of aid: ( ) Approved ( ) Denied ( ) Pending

Documentation is being sent separately by/from: _____

Do you wish to have your classroom instructors notified by the student disability services office that reasonable accommodations are requested? ( )Yes ( )No

Do you wish to have your clinical/field experience instructors notified by the student disability services office that reasonable accommodations are requested? ( )Yes ( )No

I authorize/request Calhoun Community College personnel to work on my behalf to arrange Accommodations to help meet my needs as a student at Calhoun.

Student Signature _____ Date _____

For office use only:

This was documented by the Student Disability Services/ADA Staff

_____
Signature/Date

CALHOUN
COMMUNITY COLLEGE

"Success for Every Student"