CONFIDENTIAL

STUDENT INFORMATION SHEET

We wish to work with you in your efforts toward a positive educational experience while attending our community college. To do this, we need you to tell us what your particular needs are and to release information that will allow us to communicate with the appropriate personnel. Please complete the following:

DATE___________________________

NAME____

STUDENT ID NUMBER _______________________ BIRTHDATE _______________

PERMANENT ADDRESS ____

____

TELEPHONE __________________

ENROLLMENT STATUS:

_____NEW
_____CONTINUING
_____TRANSFER
_____RETURNING

DISABILITY STATUS:

_____ TEMPORARY: ___________
(STATE HOW LONG)
_____ PERMANENT

DISABILITY:
(CHECK ALL THAT APPLY)

_____VISION
_____HEARING
_____MOBILITY/ORTHOPEDIC
_____LEARNING
_____ PSYCHIATRIC
_____CHRONIC HEALTH
_____OTHER:________________
(INDICATE TYPE)

SPECIALIZED SUPPORT SERVICES:
(CHECK ALL THAT APPLY)

______DIVISION OF VOCATIONAL REHABILITATION (DVR)
______ RECORDING FOR THE BLIND AND DYSLEXIC
______ OTHER: _________________
(INDICATE AGENCY)

BREIFLY DESCRIBE YOUR DISABILITY/DISABILITIES AND HOW IT AFFECTS YOUR ACADEMIC PERFORMANCE.

____

____

____

STUDENT NAME: _______________

RELEASE OF INFORMATION

(THIS CONSENT IS REQUIRED BY THE FAMILY EDUCATION RIGHTS AND PRIVACY ACT OF 1974)

I hereby give my permission to share information with the following persons/agencies:

____ALL AGENCIES AND/OR PERSONS WITH A LEGITIMATE EDUCATIONAL NEED TO KNOW.

(Or, check specific groups below with whom we may share information)

____Appropriate faculty
Please list: ____

____

____

____Instructional Support Staff (e.g., Library, Learning Center, etc.)

____Parents (Names) ____

____Previous/future education institutions

____ Medical/counseling facilities

____ Recordings for the Blind and Dyslexic/Library for the Blind

____ Division of Vocational Rehabilitation (DVR)

____ Other: ____

____

I understand that I must have documentation on file to be eligible for services as a student with a disability. I have a responsibility to identify myself as a person with a disability on the appropriate form designated by this college, and in the case of Federal audit, my records may be opened. Unless otherwise notified, this release of information will expire following my exit from this college.

____ ____________________
Student Signature Date

STUDENT REQUEST FOR ACCOMMODATIONS

NAME: ____ DATE: __________________

STUDENT ID NUMBER: _________________________ PHONE: _________________

I have provided documentation of my disability. Accordingly, I need the following accommodations. I will provide notification of the needs for the following in a timely manner. I understand that failure to comply with the established policies and procedures may result in the suspension of the requested service.

TESTING ACCOMMODATIONS:
(CHECK ALL THAT APPLY)

____ EXTENDED TIME ON TESTS
____ DISTRACTION REDUCED ENVIRONMENT
____ ALTERNATE FORMATS
_____ORAL
_____ BRAILLE
_____ ENLARGED PRINT
____ READER
____ SCRIBE
____ OTHER ____

CLASS ROOM ACCOMMODATIONS:
(CHECK ALL THAT APPLY)

____ NOTE TAKER
____ READER
____ SCRIBE
____ SIGN LANGUAGE INTERPRTER
____ TAPE RECORDER
____ ALTERNATIVE TEXT BOOKS
TYPE ____
____ SPECIAL SEATING
____ OTHER ____

____

____

______________________________________ ______________________
Student Signature Date

MAUI COMMUNITY COLLEGE
DISABILITY ASSESSMENT

Return to: Disabilities Coordinator

Phone: (808) 984-3227 Fax: (808)242-9618 E-mail: ldeneen@hawaii.edu

Mail: Maui Community College
310 W. Kaʻahumanu Ave.
Kahului, HI 96732
Attn: Lisa Deneen, Disabilities Coordinator

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

Date: _________________________

Phone: ________________________

Health professional's name: ____

Clinic name and address:____

____

Health professional's signature: ____

Student's Name: ____

1. **Impairment Assessment**

A. What is the diagnosis/impairment?

____

____

B. When was the diagnosis was 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 (<6months) or persistent?

____

____

2. **Major Life Activities Assessment:**

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

1= Negligible 2= Moderate 3= Substantial

	1	2	3		1	2	3
Caring for oneself				Writing			
Talking				Performing manual tasks			
Hearing				Sleeping			
Breathing				Learning			
Standing				Reading			
Working				Thinking			
Reaching				Concentrating			
Lifting				Memorizing			
Sitting				Taking Exams			
Walking				Interacting with others			
Seeing				Other			

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

____

____

____

____

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

____

____

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