To help you determine if the enrolling student has a disability, simply add the following question to your current intake/registration form. If the student marks “yes”, use the attached “Supplemental Disability Registration Form” to gain more information about their disability and needs in the classroom. This form can help you learn more about the student, if they need accommodations, and if they are an appropriate fit for Adult Basic Education.

If the student has a case worker, social worker, guardian or family member that you may want to contact, ask them to sign the “Consent for Release of Information” form. This will allow you to contact, share, and gain information from the students support system and provide you with information to best serve the individual.

Contact Wendy Sweeney at PANDA with any questions. 763-504-4095 or wendy_sweeney@rdale.org

Have you ever been diagnosed with a condition that could impact your learning (i.e. mental health, ADHD, developmental disability, learning disability, brain injury, vision or hearing loss, etc.)?

___________YES ___________NO
Supplemental Registration Form-Confidential

To learn more about you and your learning needs, please answer the following questions:

Did you ever receive special education services or given extra help in school?  ____Yes  ____No
Did you have an:  ____Individualized Education Plan (IEP)  ____  504 Plan

Please circle the category of special education services you received:
Attention Deficit Hyperactivity Disorder (ADHD), Specific Learning Disorder (SLD), Developmental Cognitive Disability (DCD, sometimes called MMR), Emotional Behavioral Disability (EBD)

Circle the type of support you received:  Small group instruction, one-on-one instruction, extended time on tests and assignments, modified assignments, after school help, summer school.
If other, please specify: ______________________________________________________________

Have you ever been diagnosed with any of the following?

Mental health condition?  ____Yes  ____No
Circle all that apply: depression, anxiety, bipolar, schizophrenia, Post-Traumatic Stress Disorder (PTSD), substance abuse.  If other, please specify: ______________________________________________________________

Attention Deficit Hyperactivity Disorder (ADHD)  ____Yes  ____No

Developmental Disability?  ____Yes  ____No
Circle all that apply: Autism, Cerebral Palsy, Downs Syndrome, Fetal Alcohol Syndrome, Intellectual Disability, Mental Retardation.  If other, please specify: ______________________________________________________________

Visual difficulties?  ____Yes  ____No
Circle all that apply: vision loss, blurry vision, words move, words fall off the page, macular degeneration.  If other, please specify: ______________________________________________________________

Hearing difficulties?  ____Yes  ____No
Circle all that apply: hearing loss, ringing in ears, deafness.

Any physical limitations?  ____Yes  ____No
Circle all that apply: mobility challenges, migraines, stroke, seizures, serious illness.
If other, please explain: ______________________________________________________________

Traumatic or Acquired Head Injury?  ____Yes  ____No
Circle all that apply: car accident, stroke, congenital, physical violence, sports injury, war injury
If other, please explain: ______________________________________________________________

Specific Learning Disability in reading, math or writing?  ____Yes  ____No
Circle all that apply: dyslexia (reading), dyscalculia (math), dysgraphia (writing).

What will help you with your learning?  Circle all that apply: breaks, extra time, testing in a private room, preferential seating, one on one instruction.  If other, please specify: ______________________________________________________________

Do you have documentation of your disability (for example, IEP, 504 Plan, a letter or document from doctor or mental health professional)?  ____Yes  ____No
Do you have a case worker or social worker?  ____Yes  ____No
Do you have a legal guardian?  ____Yes  ____No
If yes, to exchange information to help you at school, please sign the “Consent for Release of Information”.  ______________________________________________________________
Consent for Release of Information

This consent form gives ___________________________ your permission to obtain or release your Protected Health Information (PHI) as required by the Health Insurance Portability and Accountability Act (HIPAA), in order to exchange information about school and learning.

Student Name________________________________________________________
Address_________________________ City_________________________ Minnesota Zip_________
Phone_________________________ Cell_________________________ Date of Birth_____________________

Authorization Granted By:
Student Signature________________________________________ Date_____________________

Guardian Information
Guardian Name________________________________________________________
Address_________________________ City_________________________ Minnesota Zip_________
Phone_________________________ Cell_________________________
Relationship to student_____________________________________
Guardian Signature________________________________________ Date_____________________

Case Worker/Social Worker or School Official Information
I authorize ___________________________ to release or obtain information to/from:
Case Worker/Social Worker/School Name____________________________________
Phone_________________________ Fax_________________________
Email Address_________________________

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