

First Question for Supplemental Intake Form

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 PANDA with any questions at 763-504-4095 or by email at panda@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 loss, or hearing loss, etc.)?

_____ YES

_____ NO

Supplemental Registration Form-Confidential

Student Name _____ **Date** _____

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. 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 _____