

Voluntary Intake and Disability Disclosure

Baker University – Office of Disability Resources

All information obtained in diagnostic medical, psychological, and educational reports will be maintained and used in accordance with applicable confidentiality requirements.

I. General Information (all information is voluntary and optional):

Name: _____ Date: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home phone: _____ Work phone: _____ Permanent phone: _____

Social Security #: _____ Age: _____ Date of birth: _____

Male Female

Place of employment: _____ Hours worked per week: _____

University Status

- Freshman
- Sophomore
- Junior
- Senior
- Graduate/Masters
- Special
- Prospective
- Transfer from: _____

School Information

GPA: _____

Degree Program: _____

Referred By

- Professor
- Admissions
- Financial Aid
- Faculty Member
- Self
- Counseling
- Other _____

Marital Status

- Single
- Married
- Widowed
- Divorced
- Separated
- Significant other

Children/Dependents

- Yes, ages _____
- No children
- Receive financial aid?
 Yes No

Ethnic Origin

- Non-resident Alien
- Black, Non-Hispanic
- American Indian/Alaska Native
- Asian/Pacific Islander
- Hispanic
- White, Non-Hispanic
- Race/Ethnicity Unknown
- English is second language?
 Yes No

Reason for this request: _____

II. Disability Information (all information is voluntary and optional):

Please complete the following information if you have or suspect you have a disability.

Are you a student with a disability? Yes, diagnosed Suspected, not diagnosed No

If yes or suspected, describe the nature of the disability: _____

What is the nature of your impairment? Check all that apply.

Learning disability Visual impairment
 Attention deficit/Hyperactivity disorder Hearing impairment
 Chronic health disorder (please explain the nature of impairment) _____

Mobility impairment (please explain the nature of impairment) _____

Other (please explain the nature of impairment) _____

Describe your health: Good Fair Poor

Have you had previous disability counseling? No Yes Where? _____

What was the date of your last physical exam by a doctor? _____

What prescriptions are you taking or have you taken in the past? _____

How long did or do you expect to take this medication? _____

Describe any serious physical illness, injuries, or surgeries you have now or have had in the past.

Please list the accommodations you will likely request. _____

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III. Exchange of Information (optional):

In order to explore possible coverage and reasonable accommodations, it is often necessary for the staff of the Office of Disability Resources to discuss the documentation the student has submitted to our office with providers such as licensed physicians, psychologists, or other qualified professionals, and to discuss the student's impairment with Baker University faculty and professional staff.

I hereby give permission for the Director of Student Services to discuss my case with the staff of the Office of Disability Resources at Baker University to exchange information regarding the documentation I have submitted with my provider(s) (physician, psychologist, or other qualified professional), and to discuss my impairment with Baker University faculty and professional staff. I understand that my refusal to authorize consent may result in a denial of accommodations.

Student Signature

Date

Other than exceptions allowed by Kansas law and court order, information provided is confidential.

Return form to: **Director of Student Services**
Baker University
8001 College Blvd., Suite 100
Overland Park, KS 66210

Phone: 913-491-4432

Fax: 913-491-0470