Niagara University
Disability Services: Student Intake
Seton Hall, First Floor, Niagara University, NY 14109
(716) 286-8076 / Fax: (716) 286-8063 / ds@niagara.edu
www.niagara.edu/oas

To receive accommodations at Niagara University a student must:
1. Complete this intake form and return it to Disability Services each semester:  Accommodations are determined by
Disability Services on a case-by-case basis each semester.

2. Provide Disability Services with appropriate documentation of disability which verifies substantial limitation(s) of
one or more major life activities due to the disability as specified by the Americans with Disabilities Act and Section
504 of the Rehabilitation Act.

Name: _______________________________________________ Student #:____________________________

Current Address: _______________________________________________________
City: ________________________State: ______________ Zip: ____________
Phone: ______________________Cell: _______________________Email:____________________________

Major: ________________________________

Freshman Sophomore Junior Senior
Graduate Student Transfer
High School: _________________________________Transfer College: _________________________________

RELEASE OF DISABILITY INFORMATION:
I understand that my disability-related information will be used to determine my eligibility for services as mandated
under federal, state, and local law, and appropriate accommodations based on my current level of functioning.
I give permission to Disability Services to release this confidential information to my faculty and other appropriate
university personnel on a need-to-know basis.

I agree to meet with my faculty within the first two weeks of the semester to discuss my accommodations and provide
my faculty with a copy of my completed Accommodations Approval Form obtained from Disability Services.

Signature: __________________________________________________________________________

Date: _______________________________________________________________________________

What is your disability?
Attention Deficit Hyperactivity Disorder Orthopedic/Mobility Impairment:
Deaf/Hard of Hearing Blind/Visually Impaired
Specific Learning Disability: ___________________________________________________________

Other (please explain): ________________________________________________________________

Date of initial diagnosis? __________________ Who made the diagnosis? ______________________
What are your limitations? __________________________________________________________________________________________

Do you use:
Wheelchair
Hearing Aid
Service Animal (registry required)
Personal Care Attendant (registry required)

Only complete this form if you have a disability – see list below – and/or need support services
and accommodations – see back side.
Do you have a disability that would prevent you from independently evacuating a building in an emergency?

No

Yes, please provide me with emergency evacuation information.

Accommodation requests are not automatically approved. A thorough review of documentation is necessary to determine whether a student has a disability that substantially limits a major life function. The requested accommodations should be specific to the functional limitation(s). Please indicate your needs below.

**Alternative Testing:**
- Extended time
- Separate location
- Reader/Scribe
- Use of a computer (e.g., word processor, voice read-back, voice input)
- Other: ____________________________

**Adaptive Equipment Use:**
- Alternative chair/table
- Assisted listening device
- Taping of lectures
- Other: ____________________________

**Classroom Assistance:**
- Notetaker
- Preferential seating
- Sign Language Interpreter
- Other: ____________________________

**Alternative Print:**
- Audio (Electronic print, CD)
- Braille / Large Print (indicate font size: ______)
- Other: ____________________________

**Non-academic Accommodations:**
- On-campus housing accommodations
- Food service accommodations
- Other: ____________________________

**Will you receive the assistance of an outside agency (please check all that apply):**
- VESID, Counselor: ____________________________
- CBVH, Counselor: ____________________________
- Other, please specify agency and contact: ____________________________

**PARENT INVOLVEMENT:**
I give permission to Disability Services to discuss my academic/non-academic accommodations with my parents/guardians: Yes  No

Name of Parent/Guardian: __________________________________________
Student Signature: __________________________________________
Disability Services at Niagara University provides services and accommodations to persons with disabilities to ensure equal access to educational programs and activities. Current and comprehensive disability documentation from a qualified health provider (unrelated to the student) who is treating or has assessed the specific disability for which accommodations are being requested is required to assist with the determination and provision of appropriate and reasonable accommodations, auxiliary aids, and services. Additional documentation may be required.

**This form MUST be completed by a physician or other health provider.**

### I STUDENT INFORMATION

<table>
<thead>
<tr>
<th>Last Name: ___________________________</th>
<th>First Name: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth: _______________________</td>
<td>Today's Date: _________________________</td>
</tr>
<tr>
<td>Address: _____________________________</td>
<td>Phone: ________________________________</td>
</tr>
<tr>
<td>City: _______________________________</td>
<td>State: __________________ Zip: __________</td>
</tr>
</tbody>
</table>

### II CERTIFYING PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>Name &amp; Credentials: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: ____________________________________</td>
</tr>
<tr>
<td>City: __________________ State: __ Zip: _______</td>
</tr>
<tr>
<td>License number and state of licenser: _________</td>
</tr>
<tr>
<td>Signature: __________________________________</td>
</tr>
</tbody>
</table>

### III DIAGNOSTIC DATA

Detailed information is essential in determining what the individual’s current functional limitations are as well as what accommodations may be appropriate to provide in the college environment.

<table>
<thead>
<tr>
<th>Date of Initial Diagnosis: ________________</th>
<th>Date of most recent evaluation: __________</th>
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</thead>
<tbody>
<tr>
<td>Diagnosis: _______________________________</td>
<td></td>
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<tr>
<td>Secondary/Tertiary Diagnoses: ______________</td>
<td></td>
</tr>
<tr>
<td>Describe the individual’s functional limitation(s) caused by this (these) condition(s): ________________________________</td>
<td></td>
</tr>
<tr>
<td>Describe the current status of this individual’s condition(s) (e.g. Active, Progressing, Controlled, In Remission): ________________________________</td>
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</tbody>
</table>

For accommodation purposes, an individual with a disability under Section 504 and the ADA, is a person who has a physical or mental impairment that substantially limits one or more major life activities. Major life activities include, but are not limited to walking, seeing, hearing, speaking, breathing, learning, working, caring for one’s self and/or other similar activities.

Describe the major life activities currently and substantially impaired/limited by the individual’s diagnosis/condition: ________________________________
For students with the following disabilities, please attach the requested additional information:

**Cognitive Disabilities**: Most recent testing results (including tests of aptitude and achievement-full scale, not abbreviated) scores and the clinical narrative.

**ADHD/ADD**: History of ADHD/ADD, means of diagnosis, and evaluation of current impact.

**Psychological, Psychiatric or Emotional Disabilities**: Presenting symptoms and treatment. Prognosis, if know.

**Deaf/Hearing Impairment**: Audiogram required, and if available, performance section of psychological evaluation.

**Blind/Visual Impairment**: Visual acuity, field of vision, and, if applicable, CBVH certification number.

### IV THERAPEUTIC INTERVENTIONS / MEDICATIONS

Describe the therapeutic interventions and current plan for treatment including medications, dosage, and disabling side effects:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Is student compliant with therapeutic interventions? _______YES _______NO (please explain)

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Is student compliant with medication plan? _______YES _______NO (please explain)

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

V RECOMMENDATIONS FOR THE COLLEGE ENVIRONMENT

Final determination of appropriate accommodations will be determined by the Coordinator of Disability Services on a case-by-case / course-by-course basis. Determination will be made based on documentation of disability and, as needed, in consultation with appropriate campus professionals.

*Listed below are accommodations offered in the college environment. Please check the specific accommodations you recommend for this individual and include the rational for each accommodation.*

**Taking exams**
- [ ] Extended time
- [ ] Reader / scribe
- [ ] Use of calculator
- [ ] Other:

**Accessing standard print / textbooks**
- [ ] Alternate format, such as:

**Accessing class lecture / notes**
- [ ] Notetaker
- [ ] Taping Lectures
- [ ] Preferential seating
- [ ] Sign Language Interpreters
- [ ] Adaptive Chair/Table
- [ ] Assisted Listening Device
- [ ] Other:

**Scheduling classes**
- [ ] Location
- [ ] Time of classes
- [ ] Reduced course load
- [ ] Other:
Living in/off campus housing

☐ Single room  ☐ Residency exemption
☐ Room modification, please describe:
☐ Other, please list below:

Non-academic aspects of campus environment
For example, navigating campus, managing special dietary restrictions.
Please describe below:

Other

_______________________________________________________________

Rationale for each accommodation checked above:

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

All documentation of a student’s disability is kept strictly confidential and is not released without written permission from the student or by order of the court.

Please submit documentation and/or inquiries to: Diane Stoelting, Coordinator of Disability Services
Seton Hall – First Floor
Niagara University, NY 14109
Phone: (716) 286-8076 / Fax: (716)286-8063
ds@niagara.edu

RELEASE OF INFORMATION:

I, ____________________________, authorize the above physician / health provider to release to the
Niagara University’s Coordinator of Disability Services the above requested information for the purpose of determining appropriate accommodations for my permanent or temporary disability while a student at Niagara University.

Signature of student: ____________________________ Date: ___________