



XAVIER UNIVERSITY OF LOUISIANA
Counseling and Wellness Center

1 Drexel Drive • Box D
New Orleans, Louisiana 70125-1098
(504) 520-7315 • FAX (504) 520-7943
Office of Disability Services

Office of Disability Services Intake Form

PERSONAL INFORMATION

Name: _____ Today's Date ____/____/____

Address (Permanent): _____
City State Zip

Address (Local): _____
City State Zip

Date of Birth: ____/____/____ Contact # _____ Email address _____

Emergency Contact: _____ Relationship _____ Contact # _____

Were you referred Y N By Whom: _____ Title _____

ACADEMIC INFORMATION

Student ID #: 900 _____ Fall _____ Spring _____ Summer _____ Major: _____ Minor: _____

Freshman Cont. Freshman Sophomore Junior Senior COP P1 P2 P3 Other _____

DISABILITY INFORMATION

Check all that apply:

- ADD / ADHD
- Visual Impairment
- Psychological Condition (diagnosis) _____
- Learning Disability
- Deaf / Hearing Impaired
- Neurological Condition (diagnosis) _____
- Acquired Brain Injury
- Speech Impaired
- Chronic Health Related Condition (diagnosis) _____
- Physical Impairment
- Mobility Impairment
- Psychiatric / Emotional Illness (diagnosis) _____
- Temporary Accommodations
- Other _____

Date of diagnosis ____/____/____ Date of last evaluation ____/____/____ Do you have current documentation today? Yes No

Current Medications _____

List the accommodations recommended by your physician _____

Functional Limitations – How does your disability affect your academic work? _____

Do you need modifications to housing and/or dining services? Yes No If yes, describe specific modification: _____

Request for Reasonable Accommodations and / or Services:

By my signature below, I am requesting reasonable accommodations for my disability (disorder, illness, or condition). I understand that in order to receive reasonable accommodations, I must submit current documentation of my disability, disorder, illness, or condition (guidelines are outlined in the handbook) to the Office of Disability Services, be found eligible for accommodations/ services, and must request reasonable accommodations in a timely manner.

I have , I will , request(ed) documentation be sent to the Office of Disability Services by a qualified professional.

Date requested: ____/____/____ Date Received: ____/____/____ ODS Initials _____

I certify that the information provided is true to the best of my knowledge.

Student's Signature

Date

NOTE:

All documentation for ADD / ADHD and learning disabilities **must** be within the past 3 years or since the age of 18 years.

All documentation for psychological, psychiatric, or emotional disabilities, (disorders, illnesses, or condition) **must** be updated annually.

ODS does not provide copies of documentation. This information should be obtained from the originator of the documentation. ODS will retain a copy of all information within a student's file for **five (5) years**. Once the student is considered inactive for five years, the file may be destroyed.

For Office Use Only:

Staff Initials _____ Date ____/____/____

Referral Y N Source: _____

Documentation _____ Complete Date received ____/____/____
_____ Partial
_____ Referred for Testing
_____ Temporary Accommodations Provided

Modifications _____ Housing _____
_____ Dining _____



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Release of Information Consent Form

I, _____, hereby understand that by signing this form, I authorize the Office of
(Student's Name)
Disability Services (ODS) to disclose pertinent medical, psychological, educational information concerning the above-named individual to **University Officials, Deans, and Instructors.**

I have read this agreement, and fully understand. I do freely, voluntarily, and without coercion agree to those terms contained herein.

Signature _____

Date ____ / ____ / ____

Print Name _____

Contact # _____

Student ID # _____