Office of Accessibility

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STUDENT REGISTRATION FORM

Instructions: Please complete this form in its entirety. Information provided is confidential and only shared with your permission. Submit this form along with the Authorization for Information Release and current documentation of your disability.

Name _____ Today's Date _____

Student ID #_____ Birth Date _____

Home Address _____ Home Phone_____

_____
City State Zip

Campus Address _____ Cell Phone _____

Email _____@siena.edu Alt Email _____

Major _____ Anticipated Graduation Date _____

Did you transfer to Siena? If yes, from what college or university? _____

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Please list your diagnosed disabilities:

_____

_____

Accommodations/services requested at Siena College:

_____

_____

Accommodations/services received in high school or previous college:

_____

_____

Are you taking medications? If yes, please list:_____

_____

Describe adverse effects, if any: _____

_____

Please identify any other conditions(s) affecting school that you would like to discuss:

_____

_____

Current Treating Specialist: _____

Contact Information: _____

I am sponsored by: ☐ ACCES-VR (formally VESID) ☐ Commission for the Blind & Visually Handicapped

☐ Other Agency (please specify)_____

Counselor:_____ Phone #_____

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FUNCTIONAL LIMITATIONS: Please check any of the major life activities listed below that you believe are affected as a result of your diagnosed condition. Please indicate the level of limitation you believe you experience as a result of the condition.

1= Not Applicable 2 = Mild 3 = Substantial

1	2	3		---	1	2	3	
			Caring for Oneself					Learning
			Talking					• Reading
			Hearing					• Writing/Spelling
			Breathing					• Calculating
			Seeing					• Memorizing
			Walking/Standing					• Concentrating
			Lifting/Carrying					• Listening
			Sitting					Other:
			Manual Tasks					
			Eating					
			Working					