JOHNS HOPKINS UNIVERSITY

DISABILITY SUPPORT SERVICES

PEABODY REGISTRATION FORM

In order to receive accommodations, please submit a copy of your documentation regarding your disability with this form. Documentation guidelines are available at accessibility.jhu.edu. Documentation must be received before your registration is complete.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I BIOGRAPHICAL INFORMATION

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *First Middle Last*

Student ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: MALE FEMALE

Race/Ethnic Background (Optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Military Active or Veteran: \_\_\_ Yes \_\_\_ No

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*City State Zip Code*

JHU E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternate E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

II STUDENT STATUS

First Term at JHU: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_

Anticipated Date of Graduation: \_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_

Year in program: \_\_\_ 1st \_\_\_ 2nd \_\_\_ 3rd \_\_\_ 4th

Please indicate your anticipated degree: \_\_\_ BM \_\_\_ MM \_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School/Program:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

III DISABILITY INFORMATION

Disability (check all that apply):

\_\_\_\_ ADD or ADHD Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Age at Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Learning Disability: Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Age at Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Autism Spectrum: Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Age at Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Blind or Low Vision\* Date/Age at Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Deaf or Hard of Hearing\* Date/Age at Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Health Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Age at Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Mobility\* Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Age at Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Psychological Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Age at Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Traumatic/Acquired Brain Injury Date/Age at Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Age at Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_

\*Please complete the additional sections below

**Mobility** (Skip if this section does not apply to you)

Level of Mobility:

* Dexterity: \_\_\_ All \_\_\_ None \_\_\_ Limited
* Ambulatory: \_\_\_Yes \_\_\_ No \_\_\_ With minimal assistance

Do you require a personal care attendant? \_\_\_ Yes \_\_\_ No

Do you use a service animal? \_\_\_ Yes \_\_\_ No

Mobility Device Requirements:

\_\_\_ Electric Wheelchair \_\_\_ Manual Wheelchair \_\_\_ Scooter

\_\_\_ Other (Walker, crutches, cane, etc.)

**Blind & Low Vision** (Skip if this section does not apply to you)

Level of Disability

* Total Blindness
* Legally Blind
* Low Vision
* Partial vision with glasses

Do you use a Seeing Eye dog? \_\_\_ Yes \_\_\_ No

**Deaf & Hard of Hearing** (Skip if this section does not apply to you)

Level of Disability

* Completely Deaf
* Have some hearing (with aides)
* Have some hearing (without aides)
* Have hearing in one ear
* Can read lips

Supports

* Hearing Aids
* Assistive Listening Device (FM System)
* Interpreter (ASL)
* Transcriber (CART)

Please list any disability related medications you are taking:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Start date: \_\_\_\_\_\_\_\_\_\_Dosage: \_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Start date: \_\_\_\_\_\_\_\_\_\_Dosage: \_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Start date: \_\_\_\_\_\_\_\_\_\_Dosage: \_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Start date: \_\_\_\_\_\_\_\_\_\_Dosage: \_\_\_\_\_\_\_\_

Please explain how the medication helps you:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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IV SERVICE HISTORY

If you received services at a previous institution, please describe:

High School:

What was the size of your school? \_\_\_ Small \_\_\_ Medium \_\_\_ Large

Was it a school that specialized in working with students with learning disabilities? \_\_\_ Yes \_\_\_ No

Did it have Special Education/Support Services? \_\_\_ Yes \_\_\_ No

Did you use your accommodations? \_\_\_ Yes \_\_\_ No

College/University:

Name of the school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City and State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates Attended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Leaving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you request accommodations at this institution? YES NO

Were accommodations provided? YES NO

How have services you have received previously assisted you?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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For students who receive agency services: (Skip if this section does not apply to you)

Do you currently receive assistance from any of the following?

\_\_\_ Services for the Blind \_\_\_ Department of Rehabilitation Services \_\_\_ Department of Veteran Affairs

\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Rehab Counselor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

V CURRENT IMPACT STATEMENT

Functional Limitations: Please check off the activities listed below that you believe are affected as a result of your diagnosis. Please indicate level of limitation you experience as a result of the disability.

1= Unable to Determine 2= No Impact 3= Mild Impact 4= Moderate Impact 5= Substantial Impact

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **Major Life Activities** |  | **1** | **2** | **3** | **4** | **5** | **Learning / Time Management** |
|  |  |  |  |  | Caring for Oneself |  |  |  |  |  |  | Memory |
|  |  |  |  |  | Talking |  |  |  |  |  |  | Concentrating |
|  |  |  |  |  | Hearing |  |  |  |  |  |  | Listening |
|  |  |  |  |  | Breathing |  |  |  |  |  |  | Organization |
|  |  |  |  |  | Seeing |  |  |  |  |  |  | Managing distractions |
|  |  |  |  |  | Walking |  |  |  |  |  |  | Timely submission of assignments |
|  |  |  |  |  | Standing |  |  |  |  |  |  | Attending class regularly |
|  |  |  |  |  | Lifting/Carrying |  |  |  |  |  |  | Making and keeping appointments |
|  |  |  |  |  | Sitting |  |  |  |  |  |  | Managing stress |
|  |  |  |  |  | Performing Manual tasks |  |  |  |  |  |  | Reading |
|  |  |  |  |  | Eating |  |  |  |  |  |  | Writing |
|  |  |  |  |  | Working |  |  |  |  |  |  | Spelling |
|  |  |  |  |  | Interacting with others |  |  |  |  |  |  | Quantitative reasoning (math) |
|  |  |  |  |  | Sleeping |  |  |  |  |  |  | Processing Speed |

Describe in as much detail as possible how the diagnosed condition is currently impacting you (use additional paper if necessary).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Describe in as much detail as possible how the diagnosed condition has or has not impacted and substantially limited you in the past. Describe what supports you have used (use additional paper if necessary).

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If you have tried any medical or educational interventions to manage the diagnosed condition, please explain what these were and how and why they have or haven’t helped (use additional paper if necessary).

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ACADEMIC ACCOMMODATIONS RECEIVED/REQUESTING

Please check/describe any services you have received in the past under “Previously Received”.

Please check those services you are interested in requesting at JHU under “Requesting at JHU”.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Received in High school | Received in college | Requesting at JHU |
| **Classroom Accommodations:** |  |  |  |
| Access to teacher handouts, slides, overheads |  |  |  |
| Additional time on in-class writing assignments |  |  |  |
| Assistive Listening Device (FM Loop) |  |  |  |
| Assistive Technology (laptop, note taking device, etc.) |  |  |  |
| Closed Caption Video |  |  |  |
| Information on board read aloud for students with visual impairments |  |  |  |
| Interpreter/Transcriber: |  |  |  |
| ASL |  |  |  |
| CART |  |  |  |
| C-PRINT |  |  |  |
| TYPEWELL |  |  |  |
| Leave classroom when symptoms occur |  |  |  |
| Notetaker |  |  |  |
| Occasional exceptions to absentee/tardiness policy |  |  |  |
| Recorded Lectures/ Smartpen |  |  |  |
| Foreign Language Waiver or Substitution |  |  |  |
|  |  |  |  |
| **Test Accommodations:** |  |  |  |
| Additional time when taking quizzes and exams ( 1.5 or 2) |  |  |  |
| Alternate exam dates during heavy scheduling/space between |  |  |  |
| Alternative testing environment |  |  |  |
| Assistive Technology on exams |  |  |  |
| Screen Reading Software |  |  |  |
| Voice Input Software |  |  |  |
| Other |  |  |  |
| Calculator |  |  |  |
| Computer for tests |  |  |  |
| No scantron (due to visual issues) |  |  |  |
| Scribe |  |  |  |
| Spell-check or points not taken off for spelling |  |  |  |
|  |  |  |  |
| **Print Accommodations:** |  |  |  |
| Materials in Alternative Format |  |  |  |
| Braille |  |  |  |
| Electronic (DAISY, MP3, ePub,DOC, KESI, PDF) |  |  |  |
| Large Print |  |  |  |
|  |  |  |  |
| **Services:** |  |  |  |
| Adjustable Height Table in Class |  |  |  |
| Other (please explain): |  |  |  |

SERVICES RECEIVED/REQUESTING: (Skip if this section does not apply to you)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Received in High school | Received in college | Requesting at JHU |
| **Campus Access** |  |  |  |
| I cannot walk long distances quickly |  |  |  |
| I cannot walk long distances at all |  |  |  |
| I cannot go up or down stairs and need access to an elevator |  |  |  |
| Brailed Room Numbers |  |  |  |
| Raised Print Room Numbers |  |  |  |
| I use an assistive walking device that makes it difficult to get around independently during inclement weather |  |  |  |
| I use a service animal |  |  |  |
| I use a cane |  |  |  |
| I will need Orientation & Mobility training |  |  |  |
| **Emergency Evacuation** |  |  |  |
| Assistance may be required to evacuate a building |  |  |  |
| Audio/Visual Alarm |  |  |  |
| **Transportation** |  |  |  |
| I am driving and need access to handicap parking close to my classes |  |  |  |
| Independent use of the Metro |  |  |  |
| Para-Transit/Metro Access |  |  |  |

OPTIONAL:

If there are additional questions pertaining to my documentation, I give DS the right to contact the professional who completed the evaluation to obtain further information so that we can appropriately determine eligibility of services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Printed Name Date

Please send documentation to or to ask questions contact:

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Johns Hopkins University  
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