STUDENT DISABILITY INFORMATION FORM

The following information is considered confidential by LCC and will be released to NO ONE without prior written permission from the student, except in the case of medical emergency, where release of information is required by law.

Legal Name **First:** **Last:**		**Home Phone:** **Work Phone:** **Email:**	
Street Address:		**Date of Birth:**	
City: **State/ZIP**		**Student #**	

Primary Disability		☐ Permanent	☐ Temporary
Secondary Disability		☐ Permanent	☐ Temporary

Disabled Veteran?	☐ Yes	☐ No
Are you a Voc/Rehabilitation Services Client?	☐ Yes	☐ No
If Yes, your Voc/Rehab Counselors:		

Accommodations Requested:

Lamar Community College GENERAL INFORMATION

Semester at LCC: [ ] Fall [ ] Spring [ ] Summer 20____

LCC Housing information:_____

SERVICE AGREEMENT

By signing this form, the student affirms the following:

I realize that all information submitted to the Office of Accessibility will be kept confidential unless otherwise specified by the Accessibility Coordinator, or me and unless, due to a medical emergency, the release of information is necessary for my personal safety. At this time, I grant the Office of Accessibility permission to discuss my needs with my instructors or officers of the College when such discussion is deemed integral to the process of accommodation.

Signature: _____ Date: _____