

Autism Spectrum Assistance Program Application

Central Baptist College

STUDENT INFORMATION

Date: _____
Full Name: _____
Birthdate: _____ Age: _____
Home Address: _____

Phone #: _____
E-mail: _____
Current Address (If not living at home address): _____

PARENT INFORMATION

If you want Central Baptist College to be able to talk to your parent or guardian, you must complete the FERPA Form located on the ASAP website at www.cbc.edu/asap), and submit it with this application.

Parent Name: _____
Parent Address: _____

Parent Phone # _____
Parent E-mail: _____

EDUCATIONAL BACKGROUND

High School Attended: _____
Year Graduated: _____
Did you receive special services? _____
If you received special services, how long did you receive them?

Please describe the services you received: _____

What accommodations benefited you in the past? _____

Have you attended any other colleges? If so, when? _____

HEALTH/DISABILITY INFORMATION

Main diagnoses: _____

Age first diagnosed: _____

Date of latest assessment: _____

By whom? _____

Other health/medical conditions: _____

Medications taken: _____

Side effects: _____

Do you know how to take your medications? _____

Describe how your condition affects you

AT HOME: _____

AT SCHOOL: _____

WITH FRIENDS: _____

CAMPUS LIFE

Do you plan to live on campus? _____

Do you plan to have a roommate? _____

Specify your privacy, personal space or neatness needs: _____

Do you have any special dietary needs? _____

Please explain: _____

Do you have any strong dislikes or likes to certain foods? _____

Please explain: _____

OFF CAMPUS RESIDENTS

Do you plan to live with your parents? _____

Do you plan to live with another relative? _____

How will you commute to campus? _____

Do you have a driver's license? _____

Do you have a vehicle? _____

Is there any additional information you would like to share? _____

Student Signature: _____

Today's Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

_____ I HEARBY AUTHORIZE DISABILITY SUPPORT SERVICES AT CENTRAL BAPTIST COLLEGE TO DISCLOSE INFORMATION ABOUT MY DISABILITY TO CBC PROFESSORS AND PERSONNEL DIRECTLY INVOLVED IN PROVIDING ACADEMIC AND OR SUPPORT SERVICES.

*ADDITIONAL PERSONS AUTHORIZED TO RECEIVE ABOVE INFORMATION ARE:

_____ PARENT/GUARDIAN _____ DIAGNOSTICIAN _____ MENTAL HEALTH PROFESSIONAL

_____ *I HEARBY AUTHORIZE DISABILITY SUPPORT SERVICES AT CENTRAL BAPTIST COLLEGE, TO DISCLOSE AND DISCUSS MY ACADEMIC AND BEHAVIORAL ACHIEVEMENT WITH MY PARENT/GUARDIAN.

I UNDERSTAND I HAVE THE RIGHT TO INSPECT MY DISABILITY SUPPORT SERVICES FILE AND THAT THIS AUTHORIZATION IS SUBJECT TO REVOCATION.

SIGNATURE: _____

DATE: _____

WITNESS: _____

*The Family and Education Rights Protection Act (FERPA) form must be submitted with the names of individuals you allow the college to contact.