COMMUNITY EDUCATION
adult academic

Robbinsdale Area Schools Supplemental Registration Form (CONFIDENTIAL)

ROBBINSDALE area schools

Name_____ Date_____

To learn more about you and your learning needs, please answer the following questions:

Were you ever in a special education program or given extra help in school? _____Yes _____No

If yes, please explain:_____

_____

Did you have an: _____IEP _____ 504

Have you ever been diagnosed with any of the following?

Mental health condition? _____Yes _____No
Circle all that apply: depression, anxiety, bipolar, schizophrenia, PTSD, substance abuse, other
If other, please specify:_____

Attention Deficit Hyperactivity Disorder (ADHD) _____Yes _____No

Developmental Disability?_____Yes _____No
Circle all that apply: autism, cerebral palsy, down syndrome, fetal alcohol syndrome, mental retardation, other
If other, please specify:_____

Visual difficulties? _____Yes _____No
Circle all that apply: vision loss, blurry vision, vision cut

Hearing difficulties? _____Yes _____No
Circle all that apply: hearing loss, ringing in your ears, deafness

Any physical limitations? _____Yes _____No
Circle all that apply: migraines, stroke, seizures, serious illness, other
If other, please explain:_____

Traumatic Head Injury? _____Yes _____No
Please explain:_____

Specific Learning Disability in reading, math or writing? _____Yes _____No
Circle all that apply: dyslexia (reading), dyscalculia (math), dysgraphia (writing)

What other information might impact your learning? _____

_____

Do you have a case worker or social worker? _____Yes _____No

If yes, in order to exchange information to help you at school, please sign the attached consent form.

Do you have a legal guardian? _____Yes _____No

If yes, please have guardian sign the attached consent form on the next page.

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Consent for Release of Information

This consent form gives Robbinsdale Adult Academic Program staff your permission to obtain or release your Protected Health Information (PHI) as required by the Health Insurance Portability and Accountability Act (HIPAA), in order to exchange information about school and learning.

Student Name_____

Address_____ City_____ Minnesota Zip_____

Phone_____ Cell_____ Date of Birth_____

Authorization Granted By:

Student Signature_____ Date_____

Guardian Information

Guardian Name_____

Address_____ City_____ Minnesota Zip_____

Phone_____ Cell_____

Relationship to student_____

Guardian Signature_____ Date_____

Case Worker/Social Worker Information

I authorize Robbinsdale Adult Academic staff to release or obtain information to/from:

Case Worker/Social Worker Name_____

Phone_____ Fax_____

Email Address_____