_____	_____	_____
Referred By	*High School/GED*	*Year Graduated*

Laredo Community College
Special Services Center
Registration & Data Collection Form

Name: _____ DOB: _____ S.S. #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Home ( ) _____ Cell ( ) _____ Other ( ) _____

E-mail address: _____

EMERGENCY CONTACT PERSON:

Name: _____ Relationship: _____ Phone: _____

DIAGNOSTIC INFORMATION

Type of Disability (please specify):

☐ **Learning** ☐ **Physical** ☐ **Visual** ☐ **Hearing** ☐ **Psychiatric** ☐ **ADD/HD** ☐ **Other**

Are you currently seeing a physician for your condition: ☐ Yes ☐ No
Name of physician: _____ Phone No.: _____
Address: _____ City: _____ State: _____ Zip Code: _____

Are you an active client of the Department of Assistive and Rehabilitative Services (DARS)
☐ Yes ☐ No Counselor's Name: _____ Contact No. _____

Are you a client of any other Texas State Agency: ☐ Yes ☐ No
Name of Agency: _____
Contact Person: _____ Contact Phone No.: _____

If you are a client of a state agency, may we request records from your counselor and likewise provide them school-related information, such as, but not limited to, grades, course schedule, financial aid information and admission status? ☐ Yes_____ ☐ No_____

By signing the application below, we will comply with your request. Any change to the above must be communicated to the Special Services Center Office Counselor/Coordinator immediately in writing.

The attached *Release of Authorization Form*, if signed by you, will allow this office to assist you in obtaining records required to better serve you.

_____	_____
Applicant's Signature	Date
_____	_____
Counselor/Coordinator	Date