EXCELL
EXtending College Education for Lifelong Learning

NEW Student Information Packet
# Project EXCELL

## Enrollment Interview Form

<table>
<thead>
<tr>
<th>Appt. Date:</th>
<th>Time:</th>
<th>Accompanied by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Name:</td>
<td></td>
<td>Address:</td>
</tr>
<tr>
<td>Email Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Cell Phone:</td>
<td>DOB z</td>
</tr>
<tr>
<td>Age:</td>
<td>Employer:</td>
<td></td>
</tr>
<tr>
<td>Own Guardian:</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Teacher/Case Manager if still in school:</td>
<td></td>
<td>Phone:</td>
</tr>
<tr>
<td>Emergency Contact:</td>
<td></td>
<td>Phone:</td>
</tr>
<tr>
<td>Relationship:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>List: Disabilities/Diagnosis/Health Concerns/Medications:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Physicians Name: | | |
| Living accommodations: (with parents, apartment etc.) | | |
| Other program attending: | | District: |
| Last school attended: | | year: |
| Reading Level: | Comprehension: | |
| Math Level: | Comprehension: | |
| Money training: can count bills/coins: | Can make change: | |

**CHECK IF AFFIRMATIVE:**
- Capable of changing classrooms with minimal assistance
- Able to communicate with others verbally, through sign language or other communication device
- Participates in small group activities
- Able to sit through one hour class without assistance
- Follows instructions
- Attends to a specific task for 10 minutes, unaided
- Free from behavior that would be disruptive or inappropriate in a classroom
- Able to transport and take medications independently
- Does not require extensive supervision for acute or chronic medical conditions (i.e. seizures, special diets, etc.)
- Has no history in the last 2 years of physical or verbal aggression
- Has no history in the last 2 years of sexually aggressive or inappropriate behavior
- Able to maintain personal self-care and hygiene independently
- Has no history in the last 2 years of leaving a designated area without informing appropriate personnel

What would you gain from Project EXCELL classes? (in your own words) __________

Your hobbies and outside interests: ____________________________

Accommodations required: ____________________________

Notes: ____________________________

Interviewed by: ____________________________

Signature: ____________________________ Date: ____________________________
EXCELL Program
Student Health Update

Please complete this form and return to your instructor on the first day of class.

Name: _______________________________________________________

DOB: __________________________

Street: ___________________________ Phone: _________________________

City: ___________________________ State: ___________ Zip: ___________

Student Phone Number: ___________________________ Email: __________

Emergency Contact:

_________________________________ Phone: ___________ Relationship: ______

_________________________________ Phone: ___________ Relationship: ______

Name of Agency Providing Services: _______________________________ Phone: ____________

I live (check one) _____ with parents _____ in own apartment _____ in group home

List disability, any health problems, and medications: _________________________________

_________________________________________________________

_________________________________________________________

Please note any other special needs: ________________________________

_________________________________________________________

If the student has a seizure disorder, please list situations that might cause a seizure (room temperature, noise, anxiety, etc.) and what staff need to do in case of seizure.

______________________________________________________________________

Student Signature __________________________ Date: ______________________
Liability Disclaimer Statement

RE: Project EXCELL Participation for ____________________________

Student Name

I ___________________________, (student / parent / guardian) do give consent for ____________________________ (student) to participate in the Project EXCELL program during the period of time from _________________ to _________________ . I further state that I hereby release Kansas State University (the facilities agent) and UFM Community Learning Center (the fiscal agent), their agents or employees, from any claim that the stated identified participant herein might have, or others may have, for injury that said participant might sustain during his/her participation in such activities.

_____________________________  Date: ______________________
Signature of Participant

_____________________________  Date: ______________________
Signature of Parent/ Legal Guardian
PHOTO CONSENT FORM

EXCELL Program

EXtending College Education for Lifelong Learning

I, __________________________, EXCELL student, agree to allow the EXCELL Program to include me in photo displays and videos. I understand that the photo displays and videos may be used for classroom, publicity or educational purposes, and/or may be viewed on our website.

______________________________  __________________________
Student Signature                  Date

______________________________
Student Date of Birth

______________________________  __________________________
Staff or Parent/ Guardian Signature  Date

(If needed)