Santa Monica College
Center for Students with Disabilities

APPLICATION FOR SUPPORT SERVICES

Initial Date of Application for Services 9/26/23 Semester Fall Year 1
Last Name Stockton First name Graham Middle Initial W
SMC ID# 1911682 Date of Birth 02/21/2005 Age 18 Gender Male
Street Address 1200 Nottingham Lane City Chester Springs State PA Zip 19425
Primary Phone 6103967009 Secondary Phone 6106134029
Email grahamstockton6@gmail.com
Marital Status Single Educational Goal Transfer Career Goal Tech or Computer Field
Major Computer Science

Nature of Disability

Age of Onset 12 Medication (optional) _____

Types

Physical _____ Hearing _____
Learning _____ Vision _____
Health _____ Acquired Brain Injury _____
Mental Health _____ ADH/ADD ADHD
Spectrum _____ Other _____

Off Campus Affiliations

1. Are, (or were), you a client of Department of Rehabilitation? no
   If yes, name of your rehabilitation counselor _____
   Address _____ Phone _____
   E-mail _____ FAX _____
2. Are, (or were), you a client of Regional Center? no
   If yes, name of your Regional Center Counselor _____
   Address _____ Phone _____
   E-mail _____ FAX _____
3. Are you currently receiving psychological services? Yes
   If yes, name of your psychotherapist Ethan Tankel
   Address _____ Phone 6104399395
   E-mail _____ FAX _____

Emergency Contact Person

Name of person to notify in case of an emergency. Kim Stockton
Relationship to you Mother Phone# 6106134029

Educational History

Highest Grade Completed: 12th Degrees Achieved High school diploma

Please list the last two schools you have attended.

1. Name of School.
   Downingtown East HighSchool City Exton State PA
   Date Last Attended June 2023
2. Name of School.
   Downingtown Middle School City Downingtown State PA
   Date Last Attended June 2019

Employment History

Name your most recent employer, if applicable. Robert Gardner

Position Chashier Dates: From/To February 2023-July2023

I agree that if necessary for medical or educational purposes, or if necessary for the safety of myself, or others, information about me may be released to, or obtained from an instructor, relevant agency, or family member, or the Care and Prevention Team (CPT). I understand that information contained in my file will be available to the California Community College Chancellor's Office if they request it for an audit, a program evaluation, or educational research.

Signature. _____ Date 09/6/23

Medical/Educational Information Release Form

In order to receive disability-related services at Santa Monica College, a verification of disability must be provided.

Name of Physician or Agency Dr. Julie Guay, Neuropyschological Assesment and Therapy Servervices

Phone number 6102414331

Street Address 1199 Lancaster Avenue Suite 105 City Berwyn State PA Zip Code 19312

I hereby request and authorize you to release to Santa Monica College any medical/educational information pertaining to me that you may have, including diagnosis, psychological testing with raw data, Individual Educational Plan (IEP), Vocational Rehabilitation Plan, and relevant medical information. I request that the professional designated above complete this form.

Signature of Student _____ Date of Birth 02/21/2005

Print Name Graham Stockton

Signature of Parent or Guardian (if student is under 18 years old) _____

Print Name _____

THIS SECTION MUST BE COMPLETED BY THE LICENSED OR CERTIFIED PROFESSIONAL

The above student has requested support services through our Center for Students with Disabilities at Santa Monica College. To provide such services, we require certain information from you which will become part of the student record, and may be released to the student upon their written request. Please respond to the following questions:

Primary Disability

1. Diagnosis Attention Deficit Hyperactivity Disorder, Inattentive Presentation, Moderate

   DSM IV Code (if applicable) F90.0 Date of Onset 2012

   Duration of Disability: Permanent yes or temporary, how long? _____

   Please indicate the major symptoms currently manifested by the student that substantially limit major life activities and will necessitate accommodation in an academic setting.

Symptoms	Level of Severity
Slow processing speed	3 moderate
Focused and sustained visual attention	4 severe
Response control and modulation	3 Moderate
Focused and sustained auditory attention	3 Moderate

2. Is this student currently in treatment with you No

   And if so, when did you last see this student eval, 07/25/23

3. What medications are currently prescribed and what are the side effects experienced by this student that might necessitate accommodation in an academic setting?

Medication	Side Effects	Level of Severity
Lithium	None	
Paxil	None	
Lamotrigine	None	
Caplyta	None	

Signature _____ License Number: PS016479 Date: 09/28/2023

Title: Dr. Julie Guay, PsyD, ABPP-CN + Phone Number: 267-559-5626

Secondary Disability (if applicable)

1. Diagnosis _____
2. DSM IV Code (if applicable) _____Date of Onset: _____
3. Duration of Disability: Permanent _____ or temporary, how long?_____
   Please indicate the major symptoms currently manifested by the student that substantially limit major life activities and will necessitate accommodation in an academic setting.

Symptoms	Level of Severity
_____	_____
_____	_____
_____	_____
_____	_____

4. Is this student currently in treatment with you_____
   And if so, when did you last see the student? _____
5. What medications are currently prescribed and what are the side effects experienced by this student that might necessitate accommodation in an academic setting?

Medication	Side Effects	Level of Severity
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature _____ License Number:_____ Date: _____
Title: _____+ Phone Number:_____

Please print and mail to address below or scan & email to dsps@smc.edu

Nathalie Laille, M.S., Coordinator
Center for Students with Disabilities
Santa Monica College
1900 Pico Blvd.
Santa Monica, CA 90405
Phone: 310-434-4265

DSP&S Release of Information:
The Santa Monica Community College District uses the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by the Center for Students with Disabilities Program. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. Portions of this information may be shared with the Chancellor's Office of the California Community Colleges or other state or federal agencies; however, disclosure to these parties is made in strict accordance with applicable statutes regarding confidentiality, including the Family Educational Rights and Privacy Act (20 U.S.C. 1232(g)). Pursuant to Section 7 of the Federal Privacy Act (Public Law 93579; 5 U.S.C. § 552a, note), providing your social security number is voluntary. The information on this form is being collected pursuant to California Education Code Sections 67310-67312, and 84850; and California Code of regulations, Title 5, Section 56000 et seq.
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FOR OFFICE USE ONLY Date Medical Info Requested_____2nd Request_____