Documentation of Medical Need for Housing or Dining Accommodation

Form for Asthma, Environmental Allergies, or Food Allergies and Intolerances

Health Care Provider:
Your patient is a student at Wake Forest University and has indicated that they have asthma or allergies that rise to the level of disability and will require reasonable accommodations to participate in a program or activity (including housing or dining) at Wake Forest University. To consider this student's request for an accommodation because of a disability/chronic health condition, Wake Forest University requires documentation of the student's current medical condition from the treating and licensed clinical professional or health care provider thoroughly familiar with this student's condition and his/her functional limitations and/or restrictions.

The information you provide will be used to determine the nature and severity of the student's condition and the appropriateness of requested housing accommodations. *Please take the time to complete this form in its entirety.*

All information provided to us is kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA). A signed consent for release of information should be completed by the student prior to the release of this form. Thank you for your assistance.

Please Note:

- Wake Forest University has a number of residential facilities on campus that are of varying configurations and construction ranging from a typical dorm room with community bathroom, to suites, and apartments which contain private or limited access bathrooms and kitchens as well as differing types of air systems.
- All residence halls at Wake Forest University are air-conditioned, are non-smoking, and use environmentally friendly, green cleaning supplies. Allergic rhinitis does not usually merit special housing considerations (such as a single room).
- A nutritionist is available to meet with students who have food allergies to educate students on options in the on-campus dining halls and food venues.
- A desire or recommendation for a geographic change "e.g. Off-Campus" is not normally considered an accommodation.

Return Completed Form to:

Standard Mail	*Electronically*
Cecil D. Price, M.D. Director, Student Health Service Wake Forest University P.O. Box 7386, Reynolda Station Winston-Salem, NC 27109	Email: shs@wfu.edu Cecil D. Price, M.D. Director, Student Health Service Wake Forest University Fax: (336) 758-6054

If the spaces provided are not adequate, please attach a separate sheet of paper.

Student Name First: ____________________ Last: ______________________

Diagnosis: ____

Date of Diagnosis: ____

Date of last visit for this condition:_____________________________________

Procedures/assessments used to diagnose this student's condition. Please attach a copy of test results (pulmonary function testing, blood tests, allergy testing). Allergy testing is required for student's requesting special housing accommodations for environmental allergies):___________________________

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Severity of the condition (check one): ☐ Mild ☐ Moderate ☐ Severe ☐ In Remission

Has the student been treated in any emergency room or hospital for this condition within the last year?
☐ Yes ☐ No

Total number of hospitalizations for this condition:_______________________

Date of last hospitalization:____

What environmental factors exacerbate this condition? ________________________

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Does the student take prescription medication for this condition? ☐ Yes ☐ No

If yes, specify medications, dose and frequency:

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Does the student use a prescribed inhaler regularly? ☐ Yes ☐ No ☐ N/A

If the student has a food allergy, please describe the reaction or potential reaction if exposed to this allergen:

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Describe how this condition substantially limits a major life activity. Major life activities "are those basic activities that the average person in the general population can perform with little or no difficulty." 29 C.F.R. pt 1630

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Recommended accommodation (must be clearly linked to functional limitations):

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Anticipated duration of need for accommodation:

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____

If you are related to this student what is your relationship?

____

Physician's Signature:_____________________________________
Date:____

Physician's Name____
Address____

____
License/Cert. #________________________ **State:**___________________________
Specialty____
Phone:_________________________ **Fax:**_________________________________

Affix a business card or apply business stamp within this box: