SINGLE ROOM and AIR CONDITIONED ROOMS

Information Request Form

Individual’s requesting assignment to an air conditioned building and/or a single room on the basis of asthma or allergies must have their health care provider complete the following form and submit it along with a Housing Accommodation Request Form. If you do not have any other medical conditions you will not need to submit additional medical documentation.

Student Name: ______________________________________________________

ASTHMA

1. Current diagnosis (select one):
   o Exercise induced Asthma
   o Intermittent Asthma
   o Persistent Asthma
   o Other (please define): ____________________________________________

2. Current Asthma Medications (please note medication(s) name and dosage):
   o Short-acting Beta Agonists:
   o Long-Acting Beta Agonists:
   o Inhaled corticosteroids:
   o Other (please list): ____________________________________________

3. Please check any of the following which are true for your patient (dates required):
   o History of severe asthma exacerbations requiring emergency care: _______________
   o Prior intubation for asthma: ________________________________
   o Hospital admission(s) for asthma: __________________________________________
   o Prior office visits for asthma exacerbation (3 most recent visit dates): __________
   ______________________________________________________________________
   o Prior use of IM or oral corticosteroids for asthma (most recent date prescribed): __________
   o Currently requires more than 2 canisters of short-acting beta agonist per month: Yes or No

4. Are symptoms: ______ continuous ______ intermittent ______seasonal______other (please explain):
   ______________________________________________________________________

5. Severity of symptoms: _____mild _____moderate ___significant _____other (please explain):
   ______________________________________________________________________
ALLERGIES

1. Current Diagnosis:
   - Allergic Rhinitis (circle one): _______Seasonal _______Perennial
   - Allergic conjunctivitis
   - Other (diagnosis): ____________________________________________________________

2. Current Allergy medications (including medication name and frequency of daily use):
   - Antihistamines:
   - Steroid nasal inhaler:
   - Other: ________________________________________________________________

3. Please check any of the following which are true for your patient (dates required):
   - Allergies documented by skin testing or other diagnostic testing (most recent date):
   - Prior of current immunotherapy (allergy shots):
   - Other: ________________________________________________________________

4. Are symptoms: _____continuous _____intermittent _____seasonal _____other (please explain):
   ________________________________________________________________

5. Severity of symptoms: _____mild _____moderate _____significant _____other (please explain):
   ________________________________________________________________

THIS SECTION MUST BE COMPLETE FOR REQUEST TO BE PROCESSED

Physician or other Health Care Provider Information:

Name: ____________________________________________________________________

Medical Credentials: ______________________________________________________

License of Certification #: _________________________________________________

Phone: ____________________________

How long have you treated this patient: ______________________________________

Date of most recent office visit: _____________________________________________

May we contact you if we have questions about this student’s accommodation request? _______Yes ______No

Signature: __________________________________________________________________