SINGLE ROOM and AIR CONDITIONED ROOMS

Information Request Form

Individuals 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):
    - Exercise induced Asthma
    - Intermittent Asthma
    - Persistent Asthma
    - Other (please define): _____

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

3. Please check any of the following which are true for your patient (dates required):
    - History of severe asthmas exacerbations requiring emergency care:
      _____
    - Prior intubation for asthma:_____
    - Hospital admission(s) for asthma:_____
    - Prior office visits for asthma exacerbation (3 most recent visit dates):
      _____
    - Prior use of IM or oral corticosteroids for asthma (most recent date prescribed):
      _____

- 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):

   _____

***Please see next page.**

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:_____

Date:_____