Monmouth COLLEGE®

700 E Broadway
Monmouth, IL 61462
309-457-2113
309-457-2363 (fax)

Special Needs Housing Request Form (Part 2) Disability Documentation – To be filled out by health professional

Student Name: Last First Middle

Consent for Release of Information:

I, _____, give_____
Student Name Medical Provider

permission to provide the information requested below to the Monmouth College Office of Residence Life and Housing.

_____ _____
Student Signature (To be signed by parent if student is under age 18) Date

This form is to be completed by a health professional ONLY if the student has a disability for which s/he requires special housing accommodations.

We rely heavily on the information you provide to determine appropriate housing accommodations.

Thank you for your assistance.

Please note:

Unacceptable forms of Documentation

1. Handwritten patient records or notes from patient charts.
2. Diagnosis on prescription pads.
3. Self-evaluation found on internet or in any print publication, including research articles.
4. Original evaluation/diagnostic documents; submit copies of the originals.
5. Correspondence from healthcare provider not directly addressed to Monmouth College

Accommodations through the special needs housing process are only available to students identified as having a disability (Question 1).

A disability is defined under the Americans with Disabilities Act as "a physical or mental impairment that substantially limits one or more major life activities."

Examples of major life activities are: major bodily functions, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, performing manual tasks, and caring for oneself.

1. Based on this definition does the individual have a disability? _____Yes _____No

Date of original diagnosis: _____ Date of most recent evaluation:_____

Is the student currently under your care? _____Yes _____No

If the answer to question 1 is yes, please answer the following questions:

2. What specifically is the disability?_____

3. What is the expected duration, stability, or progression of the disability?
_____
_____ _____

4. Please describe current treatments, prosthetic devices, and/or medications prescribed.
_____
_____
_____

5. Is the disability completely mediated or controlled by medications, other treatments, or external prosthetics?
_____yes _____no
If no, what major life activities continue to be limited by the disability?
_____
_____

If the disability is asthma or a disabling allergy please provide additional information below about the student's condition:

B. ASTHMA

1. Current Diagnosis (select one)

- ☐ Exercise Induced Asthma
- ☐ Intermittent Asthma
- ☐ Persistent Asthma
- ☐ Other (please define)
  _____

2. Current Asthma Medications (please note medication name and dosage)

- ☐ Short-Acting Beta Agonists _____
- ☐ Long-Acting Beta Agonists _____
- ☐ Inhaled Corticosteroids _____
- ☐ Other _____

3. Please check any of the following which are true for your patient (dates required)

- ☐ History of severe asthma exacerbations requiring emergency care (most recent date)_____
- ☐ Prior intubation for asthma _____
- ☐ Hospital admission for asthma (most recent hospitalization date) _____
- ☐ Prior office visits for asthma exacerbation (most recent 3 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 _____

C. ALLERGIES

1. Current Diagnosis

- ☐ Allergic Rhinitis (Circle one): Seasonal Perennial
- ☐ Allergic Conjunctivitis
- ☐ Other (diagnosis) _____

2. Current Allergy Medications (include 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

- ☐ Allergies documented by skin testing or other diagnostic testing
- ☐ Prior or current immunotherapy (allergy shots)
- ☐ Other _____

D. HOUSING ACCOMMODATIONS

1. What housing accommodations do you certify to be **MEDICALLY NECESSARY**? Please check those that apply. (checking a box does not guarantee the accommodation)

- ☐ Air conditioning
- ☐ Single occupancy room
- ☐ Flashing Fire Alarm
- ☐ Bed shaker
- ☐ Wheel chair accessible (please specify what modifications are needed i.e. grab bars, roll-in shower etc.)
- ☐ Other

  _____

2. What housing accommodations do you consider to be **PREFERRED but NOT MEDICALLY NECESSARY**?

_____

_____

E. PROVIDER INFORMATION (Please Print)

Name: _____ Date: _____

Title: _____

Specialty: _____

Office: _____
Address, City, State, Zip

Signature: _____ Phone: _____

May we contact you if we have questions about how best to accommodate this student?
_____Yes _____No

PROVIDER: Please appropriately stamp this form showing your professional credentials or attach a copy of your letterhead confirming your professional credentials.

Return to: Office of Residence Life & Housing
Monmouth College
700 East Broadway
Monmouth, IL 61462