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.
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:____________________