CONNECTICUT COLLEGE

Student Accessibility Services
Asthma and Allergy Verification

Completing this form will help in determining disability eligibility and appropriate, reasonable accommodations for the student listed below. Thank you for your assistance in this matter. Please contact this office at (860) 439-5428 if you have any questions.

To be eligible for services your client must have a disability as defined by Section 504 of the Rehabilitation Act of 1973 or the Americans with Disabilities Act (ADA). These laws define a person with a disability as one who (1) has a physical or mental impairment which substantially limits one or more major life activities, or (2) has a record of such an impairment, or (3) is regarded as having such an impairment.

Missing information may cause a delay in our ability to evaluate the student's request for accommodations.

To Be Completed by the Student

Student's name: _____

Student's e-mail: _____ Student's phone: _____

To Be Completed by the Student's Physician
(may not be related to the student)

1. Please state diagnosis and date of diagnosis: _____
2. This student has been under a physician's care for this issue since: _____
3. Date the student was last seen by you: _____
4. Expected duration of impairment/disability: _____
5. How often is the student required to check-in with you? _____
6. Procedures/ assessments used to diagnose this student's condition (please attach a copy of the test results; ie allergy testing, pulmonary function testing, etc):

7. What is the severity of the condition (mild, moderate, substantial, in remission)?_____

Check all relevant functional limitations AND explain how each will affect your patient in the academic environment:

FUNCTIONAL LIMITATIONS	Mild	Moderate	Substantial	Comments
Caring for oneself				
Performing manual tasks				
Seeing				
Hearing				
Breathing				
Sleeping				
Eating				
Standing				
Lifting				
Bending				
Walking				
Speaking				
Learning				
Reading				
Concentrating				
Thinking				
Communicating				
Working				
Operation of a major bodily function				
Other				

8. Has the student been treated in the emergency room or hospital for this condition in the last year?_____

9. Total number of hospitalizations for this condition: _____Date of last hospitalization:_____

10. Does the student use an inhaler regularly?_____

11. Does the student use a Nebulizer for this condition?_____

12. Does the student take prescription medication to this condition?_____
    If yes, please specify medications, dosage and frequency:

Medication	Dosage	Frequency

13. What environmental factors exacerbate this condition?_____

14. **Please provide your recommendation for reasonable accommodation(s) for this student and how these accommodations will address specific functional limitations :**

15. Please state alternatives to meet the documented need if the request cannot met:

16. Additional comments:

Physician's Signature: _____ Date _____

Physician's Name (please print) /Academic Credentials _____

License/Certification # _____ State _____

Address _____

City, State, Zip code _____

Phone _____ Fax _____

Please send all documentation to:

Office of Student Accessibility Services
Connecticut College
Campus Box 5264
270 Mohegan Avenue
New London, CT 06320