

SECTION I: TO BE COMPLETED BY STUDENT

CURRY COLLEGE

Air Conditioning Request Due to Medical Condition

Medical Condition

Name:		Class Year:
First M.I. Curry Email Address:	Last@students.curry.edu	Curry ID #: @00
Consent for Release of Information: I,		(Student name), give
	(Healthcare provider	's name) permission to provide the information
requested below to Health Services at Curry Co	ollege.	
Student Signature (or legal guardian if under	r 18 years of age)	Date
ACCOMMODATION IS NECESSARY. OFFICE STAthe student by blood or marriage. Please note: Many of the residence halls at Cuprovide air conditioners for their rooms except conditions are substantially limiting to a major condition qualifies as a disability.	AMP REQUIRED. The healthcar arry College are not air cond in rare instances of medical life activity must provide det	condition or disability. The students whose ailed medical documentation to show why the
Name of Healthcare Provider:		
Address:		
	State:	Zip:
Date of most recent office visit by this patient:		
How long have you treated this patient for an a	llergic or other significant me	edical condition?
Type of allergy or significant medical condition	:	
Please provide the diagnosis, functional limitati justification for recommendation(s) on pages to acceptable).		,

□ Leukotriene: □ Other: 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 visit for asthma exacerbation (three most recent visit dates): □ Prior use of IM or Oral Corticosteroids for asthma (most recent date prescribed): □ Currently requires more than two canisters of Short-Acting Beta Agonist per month Are symptoms: □ Continuous □ Intermittent □ Seasonal Other (please explain): Severity of symptoms: □ Mild □ Moderate Significant Other (please explain): □ Other (please explain): □ Moderate Other (please explain): □ Other (please explain):	Intermittent Asthma Persistent Asthma Persistent Asthma Other (please define):	TION III: 2	ASTHMA			
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Are s	ymptoms: _	Continuous		Intermittent		Seasonal
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Description of the student's functional limitation residence hall setting:	on(s) or behavioral manifestation(s) in a college
Healthcare Provider Comments: Please list your spaceommodation needs for this student in a college resident	
Signature of Healthcare Provider	Date
return this completed form and any supplemental docum College a Services Blue Hill Avenue	
return this completed form and any supplemental docum College a Services Blue Hill Avenue a, MA 7-333-2182	
Signature of Healthcare Provider return this completed form and any supplemental docum College n Services Blue Hill Avenue n, MA 17-333-2182 7-333-2029 services@curry.edu	
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