CURRY COLLEGE

Air Conditioning Request Due to Medical Condition

SECTION I: *TO BE COMPLETED BY STUDENT*

Name: _____ Class Year: _____ Curry ID #:_____
First M.I. Last

Curry Email Address: _____@students.curry.edu Residence Hall and Room: _____

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 College.

_____ _____
Student Signature (or legal guardian if under 18 years of age) Date

SECTION II: *TO BE COMPLETED BY A HEALTHCARE PROVIDER MANAGING THE MEDICAL CONDITION FOR WHICH THIS ACCOMMODATION IS NECESSARY. OFFICE STAMP REQUIRED. The healthcare provider cannot be a friend of the family or related to the student by blood or marriage.*

Please note: Many of the residence halls at Curry College are not air conditioned, nor are the students permitted to provide air conditioners for their rooms except in rare instances of medical condition or disability. Students requesting permission to install an air conditioner in their bedroom window are required to submit documentation to determine eligibility in accordance with Section 504 of the Rehabilitation Act of 1973, as amended, and the Americans with Disabilities Act of 1990, as amended. If approved, the student is responsible for providing their own window unit that will be installed by Buildings and Grounds. The students whose conditions are substantially limiting to a major life activity must provide detailed medical documentation to show why the condition qualifies as a disability.

Name of Healthcare Provider: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of most recent office visit by this patient: _____

How long have you treated this patient for an allergic or other significant medical condition? _____

Type of allergy or significant medical condition: _____

Please provide the diagnosis, functional limitation(s), recommendation(s) regarding accommodation needs, and your justification for recommendation(s) on pages two (2) and/or three (3) of this form only (Note: No other forms will be acceptable).

SECTION III: ***ASTHMA***

Current Diagnosis *(select one):*

☐ Intermittent Asthma
☐ Persistent Asthma
☐ Other *(please define)*: _____

Current Asthma Medications *(please note the medication, dosage, and frequency):*

☐ Short-acting Beta Agonists: _____
☐ Long-acting Beta Agonists: _____
☐ Inhaled Corticosteroids: _____
☐ 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):* _____

Description of the student's functional limitation(s) or behavioral manifestation(s) in a college residence hall setting: _____

_____

_____

_____

Healthcare Provider Comments: Please list your specific recommendation(s) for reasonable housing accommodation needs for this student in a college residence hall: _____

_____

_____

_____

SECTION IV: ***ALLERGIES***

Current Diagnosis *(select one):*

☐ Allergic Rhinitis
☐ Environmental Allergies (*please specify*): _____
☐ Seasonal Allergies (*please specify*): _____
☐ Other *(please define)*: _____

Current Allergy Medication(s) *(please note the medication, dosage, and frequency):*

☐ Anti-histamines: _____
☐ Steroid Nasal Inhaler: _____
☐ Other: _____

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 or current immunotherapy *(allergy shots)*: _____

Are symptoms: _____ Continuous _____ Intermittent _____ Seasonal

Other *(please explain)*: _____

Severity of symptoms: _____ Mild _____ Moderate _____ Significant

Other *(please explain):* _____

Description of the student's functional limitation(s) or behavioral manifestation(s) in a college residence hall setting:

_____

_____

_____

Healthcare Provider Comments: Please list your specific recommendation(s) for reasonable housing accommodation needs for this student in a college residence hall:

_____

_____

_____

SECTION V. OTHER MEDICAL CONDITIONS:

Current Diagnosis: _____

Describe symptoms and severity of symptoms:

_____

Current medications or treatment required for this condition (please note medication, dosage and frequency)

Description of the student's functional limitation(s) or behavioral manifestation(s) in a college residence hall setting:

Healthcare Provider Comments: Please list your specific recommendation(s) for reasonable housing accommodation needs for this student in a college residence hall:

Signature of Healthcare Provider

Date

Please return this completed form and any supplemental documentation to:

Curry College
Health Services
1071 Blue Hill Avenue
Milton, MA
(T) 617-333-2182
(F) 617-333-2029
healthservices@curry.edu