Verification of Disability Form for Housing Accommodations for Asthma and Allergy Conditions

Healthcare Provider: Please complete both pages of this form in its entirety so that we can determine the nature and severity of the student's condition and appropriateness of the requested accommodations.

The student below has indicated that s/he has asthma or allergies that rises to the level of a disability and requires housing accommodations.

If you have any questions, please contact the Haverford Office of Access and Disability Services (ADS) at hc-ads@haverford.edu or 610-896-1324.

Student Name: ________________________________________________

Diagnosis: _____________________________________________________

Date of Diagnosis: _____________________________

Date of last visit for this condition: ______________________________

Severity of the condition (circle one) Mild Moderate Severe In Remission

What environmental factors exacerbate this condition? ____________________________
__________________________________________________________________________
__________________________________________________________________________

What symptoms does the student experience as a result of this condition? ______
__________________________________________________________________________
__________________________________________________________________________

Does the student take medication for this condition? _____ Yes _____ No

If yes, please specify medications: ____________________________________________

Does the student use a prescribed inhaler regularly? _____Yes _____ No
What are the functional limitations caused by this condition and/or its treatment and how will that impact the student in college?

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Recommended accommodations (must be clearly linked to the functional limitations):

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Anticipated duration of the need for the accommodations: ___________________________

________________________________________________________________________________

________________________________________________________________________________

Print Name of Medical Professional: ______________________________________________

State and License #: ___________________________________________________________

Address: ___________________________________________________________________

Telephone: ___________________________________________________________________

Signature of Medical Professional: ______________________________________________

Date: ______________________________________________________________________

Please return this form to Haverford College, Office of Access and Disability Services by fax: 1-833-243-2760, or scan to hc-ads@haverford.edu, or mail to Haverford College, Access and Disability Services, Stokes 111 370 Lancaster Ave. Haverford, PA 19041