

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

Medical Professional: 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 they have asthma or allergies that rise to the level of a disability and requires housing accommodations.

The Americans with Disability Act (ADA) defines a disability "as a physical or mental impairment that substantially limits a major life activity; a record of such an impairment; or being regarded as having such an impairment." In determining the extent of one's limitation, the nature, severity, duration, and impact of the impairment are relevant factors.

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 they 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: _____

Credentialed Professional (circle one) M.D. D.O. PA NP

Specialty or Board Certification: _____

State and License #: _____

Address: _____

Telephone: _____

I concur that the patient's asthma and/or allergy rises to the level of a disability under the law and requires housing accommodations.

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