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?
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

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: 610-795-6116, or scan to hc-ads@haverford.edu, or mail to Haverford College, Access and Disability Services, Stokes 111 370 Lancaster Ave. Haverford, PA 19041