

Health Care Form for Students Requesting Housing Accommodations

In order to evaluate how we can best meet your needs, we require specific information from both you and your examiner. You must complete the top portion of the form below. Also, to facilitate the process, we need you to fill out and sign the Authorization to Receive Health Care Information below. This gives us permission to speak with your examiner if we have questions relating to his/her recommendation for accommodation(s). Your health care provider must complete the rest of this form, sign it, and return the completed packet to the above address.

Student Fills Out This Section:

(Please Print or Type):

Student Name: _____
(Last)
(First)
(Middle)

Student ID Number: _____

Birth Date: _____ Gender: ___ Male ___ Female

Home Address: _____

Home Phone #: _____

Local Address: _____

Local Phone #: _____ E-Mail Address: _____

AUTHORIZATION TO RECEIVE INFORMATION: I authorize the Office for Residence Life to receive information from the provider below. I also authorize my provider to discuss my condition(s) with the Office for Residence Life.

Name of Provider: _____

Address (Street, City, State, and Zip): _____

Student's Signature: _____ Date: _____

Medical/Health Care Provider Fills Out and Signs Section Below:

STUDENT'S NAME: _____

Provider Completes the Section Below:

Southeast Missouri State University provides accommodations and support services to students with diagnosed disabilities. A student's documentation regarding their condition must demonstrate they have a disability covered under the Americans with Disabilities Act (ADA; 1990). ***The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.** To determine eligibility for services and accommodations, this office requires current and comprehensive documentation of the student's disorder from the diagnosing physician or health care provider. **Items 1 thru 6 must be completed in full.** If space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related information.

Please respond to the following items regarding the student named above:

1) What is the student's medical condition/diagnosis? _____

a) How long has the student had this condition? _____

b) What is the severity of the condition? _____

c) How long is this condition likely to persist? _____

2) Describe the symptoms related to the student's condition that cause **significant** impairment in a major life activity.

3) List this student's current medication(s), dosage, frequency, and adverse side effects.

a) Are there significant limitations to the student's functioning directly related to the prescribed medications? Yes _____ No _____

b) If yes, please describe.

4) Does the student have a disability* as a result of this condition? _____ Yes _____ No

5) If yes, please state specific recommendations regarding housing accommodations for this student, and a rationale as to why these housing accommodations are warranted based upon the student's functional limitations. Indicate why the housing accommodations you recommend are necessary (e.g., if you suggest air conditioning state the reasons for this request related to the student's disability).

6) If current treatments (e.g., medications) are successful, why are the above housing accommodations necessary?

The provider may also send a report that provides additional related information.

Signature of Provider: _____ Date: _____

(Please print) Name/Title: _____

Address: _____

Phone: _____

Fax: _____

Return Address:

Office for Residence Life
One University Plaza MS 0055
Cape Girardeau, MO 63701.

Fax 573-651-2557