RIDER UNIVERSITY

Accommodations ▪ Coaching ▪ Consultation

Student Accessibility and Support Services
Bart Luedeke Center
2083 Lawrenceville Road
Lawrenceville, NJ 08648-3099
T 609-895-5492
accessibility@rider.edu
www.rider.edu/sass

Returning Students : March 1st

New/Transfer Students: May 1st

Housing/Dining Accommodation Request for Students with Disabilities or Severe Medical Issues

Directions

Students:

- Complete Part I
- Sign the Consent for Release of Information on p. 2
- Provide entire form to your disability evaluator or physician

Disability Evaluators and Physicians:

- Complete Part II for all student accommodation requests, including page 7.
- Also, complete Part III, only if the student is requesting dietary modifications.
- Include any relevant reports substantiating student's accommodation request.
- Return the entire Housing/Dining Accommodation Request to Student Accessibility and Support Services by email or the US Postal Service (address/email on final page).

***ADDITIONAL INFORMATION:

- The Housing/Dining Accommodations Committee reviews your request.
- Decisions are based on the information provided by you and your disability evaluator or physician. It is required that complete, detailed information be provided by a qualified professional in the medical field for the disability requiring the accommodation. For example: Mental Health Provider for Psychosocial/Emotional diagnosis like Depression or Anxiety. Incomplete forms will not be reviewed. Appeals are considered only when new information is provided.
- The Housing/Dining Accommodations Committee reserves the right to ask for additional documentation and/or meet with the student, if such information is needed to make an accommodation decision. • Accommodation decisions are communicated to the student via email from Residence Life and/or Student Accessibility and Support Services.
- Requests for Fall are due March 1st for returning students and May 1 for new students.
- **Failure to meet the due date may result in the University not being able to provide the requested accommodation.**

Part I: Student to complete the following:

Name (please print clearly):_____

Bronc ID#: _____

Student Cellular #: _____

Rider Email: _____

Status: Incoming Freshman___ Transfer___ Returning___

Accommodation Request is for: Semesters (i.e.,Fall/Spring)_____(Calendar)Years:_____

1. State your disability for which you are requesting a Housing/Dining Accommodation:

_____

_____

2. What Housing/Dining accommodation are you requesting?

_____

_____

3. Please describe how this accommodation will reduce the impact of your disability in the residence hall/dining hall.

_____

_____

_____

4. Please add any other information you feel is important for us to consider in reviewing your request.

_____

_____

5. Do you have a mobility or other concern that would prevent you from evacuating a building in case of emergency? Yes___ No___

6. Would you like Student Accessibility and Support Services to contact you regarding disability related academic accommodations or support services? Yes___ No___

Student Signature:_____ Date:_____

Consent for Release of Information (to be completed by student):

I authorize_____ (physician or evaluator's name) to disclose the information requested by this form to the Student Accessibility and Support Services Office and Student Health Center of Rider University for the purpose of evaluating my request for Housing/Dining accommodations. I also allow both parties to discuss any information related to my Housing/Dining accommodation request.

Student Signature:_____ Date: _____

Student's Name:_____

Part II: Physician or Disability Evaluator to complete the following:

PROFESSIONAL EVALUATION OF DISABILITY

Accommodations are only available to students identified as having a disability or severe medical issue. **A disability is defined under the Americans with Disabilities Act as "a physical or mental impairment that substantially limits one or more major life activities."**

Examples of major life activities are: Major bodily functions, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, performing manual tasks, and caring for oneself.

1. Based on this definition, does the individual have a disability? Yes___ No___

   Date of original diagnosis_____: Date of most recent evaluation:_____

   Is the student currently under your care? Yes___ No___

2. State the student's disability diagnosis: _____

_____

_____

3. State the diagnostic code(s):

_____

4. Describe the **frequency**, **duration**, **stability**, and **progression** of the disability.

_____

_____

_____

5. Describe current treatments, prosthetic devices, and/or medications prescribed.

_____

_____

_____

6. Is the disability mediated or controlled by medications, other treatments, or external prosthetics?
   Yes___No___. Please explain: _____

_____

_____

7. Please state specific recommendations for reasonable Housing/Dining accommodations to address the functional limitations noted in the chart on page 4._____

_____

_____

Student's Name_____

8. Check any areas of functioning impacted by the disability. Explain the limitation on functioning. Indicate the degree of limitation. This information should support the recommended accommodations in Part II.

Area of Functioning (check)	Limitation on Functioning (explain)	Degree of limitation
□ Hearing		Mild Moderate Severe
□ Vision		Mild Moderate Severe
□ Speech		Mild Moderate Severe
□ Manual Dexterity		Mild Moderate Severe
□ Ambulation		Mild Moderate Severe
□ Motor Coordination		Mild Moderate Severe
□ Activities of Daily Living		Mild Moderate Severe
□ Endurance		Mild Moderate Severe
□ Respiratory		Mild Moderate Severe
□ Climatic/Environment		Mild Moderate Severe
□ Cognitive Skill		Mild Moderate Severe
□ Sleep		Mild Moderate Severe
□ Social Interaction		Mild Moderate Severe
□ Eating		Mild Moderate Severe
□ Other		Mild Moderate Severe

Student's Name: _____

9. ASTHMA

A. Current diagnosis (select one):

☐ Exercise induced Asthma
☐ Intermittent Asthma
☐ Persistent Asthma
☐ Other (please define): _____

B. Current Asthma Medications (please note medication(s) name and dosage):

Type	Medication Name	Dosage
Short-acting Beta Agonists		
Long-acting Beta Agonists		
Inhaled corticosteroids		
Other		

C. Please check any of the following which are true for your patient (**dates required**):

	Dates
___History of severe asthma exacerbations requiring emergency care	_____
___Prior intubation for asthma	_____
___Hospital admission for asthma	_____
___Prior office visits for asthma exacerbation	_____
___Prior use of IM or oral corticosteroids for asthma	_____

___Currently requires more than 2 canisters of short-acting beta agonist per month: Yes___ No___

D. Are symptoms:___continuous___intermittent___seasonal___other___(please explain):_____

E. Severity of symptoms:___mild___moderate___ significant___ other (please explain):_____

10. **ALLERGIES**

A. Current Diagnosis:

___Allergic Rhinitis (circle one): *Seasonal__Perennial___*
___Allergic conjunctivitis
___Other: explain:_____

B. Current Allergy medications (including medication name and frequency of daily use):

Type	Medication Name	Dosage
Antihistamines		
Steroid nasal inhaler		
Other		

Student's Name_____

C. Please check any of the following which are true for your patient (dates required):

Please check:	**Dates:**
___Allergies documented by skin testing or other diagnostic testing	
___Prior or current immunotherapy (allergy shots)	
___Other:_____	

D. Are symptoms:___ continuous___ intermittent___seasonal___ other (please explain):_____

E. Severity of symptoms:___mild___moderate___significant___ other (please explain):_____

Student's Name: _____

Part III. Dietary Modifications Request

Your patient is seeking dining accommodations due to a medical condition. Student seeking dining accommodations must have a diagnosis that makes these dietary modifications medically necessary. No accommodations will be made regarding food preferences.

For Food Allergies:

Patient is allergic to: (Please check all that apply.)

___Dairy	___Eggs	___Fish
___Peanuts	___Shellfish	___Soy
___Tree Nuts	___Wheat/Gluten	

Other (please specify) _____

If there is another medical condition that requires dietary accommodations, please specify details here**:**

_____

_____

_____

DIET PRESCRIPTION

Please provide a list of food items that must be omitted from your patient's diet and a list of safe and appropriate substitutions

OMITTED FOOD	SUBSTITUTION (if applicable)

Length of time dietary accommodations will be required (check one):

Ongoing___ Temporary___ If Temporary: Start:_____ End:_____

Student's Name: _____

THIS SECTION MUST BE COMPLETED FOR FORM TO BE VALID

Physician or disability evaluator who completed this Form: (Please Print)

Name: _____

Title:_____Specialty: _____

Office Address:_____

Phone: _____

How long have you treated this patient? _____

Date of most recent office visit: _____

Signature:_____ Date:_____

PROVIDER:

- ✓ Please include a copy of your letterhead **OR**
- ✓ A voided prescription **OR**
- ✓ Use your office stamp on this document

PLEASE MAIL or EMAIL COMPLETED FORM TO:

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