



Accommodations ▪ Coaching ▪ Consultation

Student Accessibility and Support Services
Bart Luedeke Center
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Returning Students: February 1

New/Transfer Students: May 1

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 February 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: _____

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 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
<input type="checkbox"/> Hearing		Mild Moderate Severe
<input type="checkbox"/> Vision		Mild Moderate Severe
<input type="checkbox"/> Speech		Mild Moderate Severe
<input type="checkbox"/> Manual Dexterity		Mild Moderate Severe
<input type="checkbox"/> Ambulation		Mild Moderate Severe
<input type="checkbox"/> Motor Coordination		Mild Moderate Severe
<input type="checkbox"/> Activities of Daily Living		Mild Moderate Severe
<input type="checkbox"/> Endurance		Mild Moderate Severe
<input type="checkbox"/> Respiratory		Mild Moderate Severe
<input type="checkbox"/> Climatic/Environment		Mild Moderate Severe
<input type="checkbox"/> Cognitive Skill		Mild Moderate Severe
<input type="checkbox"/> Sleep		Mild Moderate Severe
<input type="checkbox"/> Social Interaction		Mild Moderate Severe
<input type="checkbox"/> Eating		Mild Moderate Severe
<input type="checkbox"/> 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:
<input type="checkbox"/> Allergies documented by skin testing or other diagnostic testing	
<input type="checkbox"/> Prior or current immunotherapy (allergy shots)	
<input type="checkbox"/> 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.)

<input type="checkbox"/> Dairy	<input type="checkbox"/> Eggs	<input type="checkbox"/> Fish
<input type="checkbox"/> Peanuts	<input type="checkbox"/> Shellfish	<input type="checkbox"/> Soy
<input type="checkbox"/> Tree Nuts	<input type="checkbox"/> 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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