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

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 recommended that complete, detailed information be provided by a qualified professional. 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 are due February 1 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

Campus:    ☐Lawrenceville    ☐Princeton/WCC

Updated 2/28/2019
Accommodation Request is for: Semester(s): ________________ Year: ______

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

<table>
<thead>
<tr>
<th>Area of Functioning (check)</th>
<th>Limitation on Functioning (explain)</th>
<th>Degree of limitation (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Hearing</td>
<td></td>
<td>Mild  Moderate  Severe</td>
</tr>
<tr>
<td>□ Vision</td>
<td></td>
<td>Mild  Moderate  Severe</td>
</tr>
<tr>
<td>□ Speech</td>
<td></td>
<td>Mild  Moderate  Severe</td>
</tr>
<tr>
<td>□ Manual Dexterity</td>
<td></td>
<td>Mild  Moderate  Severe</td>
</tr>
<tr>
<td>□ Ambulation</td>
<td></td>
<td>Mild  Moderate  Severe</td>
</tr>
<tr>
<td>□ Motor Coordination</td>
<td></td>
<td>Mild  Moderate  Severe</td>
</tr>
<tr>
<td>□ Activities of Daily Living</td>
<td></td>
<td>Mild  Moderate  Severe</td>
</tr>
<tr>
<td>□ Endurance</td>
<td></td>
<td>Mild  Moderate  Severe</td>
</tr>
<tr>
<td>□ Respiratory</td>
<td></td>
<td>Mild  Moderate  Severe</td>
</tr>
<tr>
<td>□ Climatic/Environment</td>
<td></td>
<td>Mild  Moderate  Severe</td>
</tr>
<tr>
<td>□ Cognitive Skill</td>
<td></td>
<td>Mild  Moderate  Severe</td>
</tr>
<tr>
<td>□ Sleep</td>
<td></td>
<td>Mild  Moderate  Severe</td>
</tr>
<tr>
<td>□ Social Interaction</td>
<td></td>
<td>Mild  Moderate  Severe</td>
</tr>
<tr>
<td>□ Eating</td>
<td></td>
<td>Mild  Moderate  Severe</td>
</tr>
<tr>
<td>□ Other</td>
<td></td>
<td>Mild  Moderate  Severe</td>
</tr>
</tbody>
</table>
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):

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-acting Beta Agonists</td>
<td></td>
</tr>
<tr>
<td>Long-Acting Beta Agonists</td>
<td></td>
</tr>
<tr>
<td>Inhaled corticosteroids</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

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

- 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

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):

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antihistamines</td>
<td></td>
</tr>
<tr>
<td>Steroid nasal inhaler</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

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

- 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): ___________
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

<table>
<thead>
<tr>
<th>OMITTED FOOD</th>
<th>SUBSTITUTION (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________________</td>
<td>____________________________</td>
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<td>__________________</td>
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<tr>
<td>__________________</td>
<td>____________________________</td>
</tr>
</tbody>
</table>

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

- Ongoing ___
- Temporary ___
- If Temporary: Start: _______ End: _______
Student’s Name: ______________________________

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, EMAIL, or FAX COMPLETED FORM TO:

Student Accessibility and Support Services
Joseph P. Vona Academic Annex, Room 8
Rider University
2083 Lawrenceville Road
Lawrenceville, NJ 08648-3099
Email: accessibility@rider.edu
Fax: 609-895-5507
Phone: 609-895-5492