RIDER UNIVERSITY

*Accommodations ▪ Coaching ▪ Consultation*

**Returning Students: March 1st**

**New Students: May 1st**

**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

# 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 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

Student's Name: _____

Accommodation Request is for: Semesters (Fall/Spring): _____ 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. 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 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.

_____

_____

Student's Name: _____

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.

| **Area of Functioning (check)** | **Limitation on Functioning (explain)** | **Degree of limitation (circle)** |
|---|---|---|
| ☐ 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 |

**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):

| | 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):

| | Medication Name | Dosage |
|---|---|---|
| ☐ Antihistamines | | |
| ☐ Steroid nasal inhaler | | |
| ☐ Other _____ | | |

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

| | 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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