Services for Students with Disabilities
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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 8.
- Also, complete Part III, only if the student is requesting air conditioning in the residence hall due to asthma or allergies.
- Also, complete Part IV, only if the student is requesting dietary modifications due to food allergies.
- Include any relevant reports substantiating student's accommodation request.
- Return the entire Housing/Dining Accommodation Request to Services for Students with Disabilities by email or the US Postal Service (address/e-mail 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.*
- *Requests are due February 1 for returning students and May 1 for new students.*

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

Accommodation Request is for: Semester(s):_____ Year: _____

Student's Name:_____

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 Services for Students with Disabilities 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 Services for Students with Disabilities 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.

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

Part III. Air Conditioner Requests for Asthma and Allergies

Air conditioning requests should be made only for extreme medical circumstances. Note that allergies rarely meet this criteria.

ASTHMA

1. Current diagnosis (select one):
   - ☐ Exercise induced Asthma
   - ☐ Intermittent Asthma
   - ☐ Persistent Asthma
   - ☐ Other (please define): _____

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

	Medication Name	Dosage
☐ Short-acting Beta Agonists		
☐ Long-Acting Beta Agonists		
☐ Inhaled corticosteroids		
☐ Other _____		

3. 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)

4. Are symptoms: __continuous _intermittent __ seasonal __other (please explain) _____

5. Severity of symptoms: __mild ___moderate __ significant __ other (please explain)_____

ALLERGIES

1. Current Diagnosis:
   - ☐ Allergic Rhinitis (circle one): *Seasonal Perennial*
   - ☐ Allergic conjunctivitis
   - ☐ Other: explain _____

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

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

3. 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:_____	_____

4. Are symptoms:___continuous ___intermittent ____seasonal ___other (please explain):_____

5. Severity of symptoms: ___mild __moderate ___significant ___other (please explain):_____

Part IV. 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.

- **Note that meal plan exemptions are rare, since the dining hall is prepared to work with various dietary allergies and provide safe meals.**

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: _____

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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