Residence Life
Medical Housing Request Form

Verification Form for Students Requesting Changes to the Housing Environment Due to a Significant Chronic Physical or Emotional Condition

In order to evaluate how Le Moyne College can best meet a student's needs for special housing assignment requests, the College requires specific diagnostic information from a licensed clinical professional or health care provider. This professional/provider should be familiar with the history and functional limitations of the student's physical or psychological condition(s). The student must complete page one of the form below. Also, to facilitate the process, Le Moyne College requires the student to fill out and sign the Authorization to Receive Health Care Information below. This signature provides the appropriate and qualified Le Moyne College staff member permission to speak with the provider who completes the information on this form, and if the student desires, the permission to discuss the student's condition or resulting determination with a person of the student's choosing. The provider must fill out pages two and three, sign, and return the completed packet:

Mail: **Office of Residence Life**
1419 Salt Springs Rd
Syracuse, NY 13214

Fax: **315.445.6010**

Student Fills Out the Section Below. Please Print or Type.

Student Name: _____
(Last) (First) (Middle)

Student ID: _____ Email: _____

Birth Date: _____ Gender: Male _____ Female _____

First Semester Enrolled at Le Moyne: _____ Current Semester Standing: _____

Home Address: _____ Local Address: _____

_____ _____

Home Phone: _____ Local Phone: _____

I authorize Le Moyne College to <u>receive</u> information <u>from</u> the provider below. I also authorize my provider to discuss my condition(s) with the appropriate and qualified Le Moyne College personnel on an as needed basis.

Name of Provider: _____

Address (Street, City, State, Zip): _____

(OPTIONAL) I authorize Le Moyne College to exchange applicable information with the following person(s) on my behalf:

Name: _____ Relationship to student: _____

Address and Phone: _____

Student's Signature: _____ **Date**: _____

Medical/Health Care Provider Fills Out and Signs Section Below:

STUDENT'S NAME: _____

Provider Completes the Section Below:

To determine eligibility for changes to the housing environment, the Le Moyne College requires current and comprehensive documentation of the student's condition from a licensed clinical professional or health care provider familiar with the history and functional limitations of the student's condition(s). The provider completing this form cannot be a relative of the student. **Items 1 thru 5 must be completed in full.** If the space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related information.

Please respond to the following items regarding the student named above:

1) What is the student's medical condition/diagnosis? _____

_____

_____

a) How long has the student had this condition? _____

_____

_____

b) What is the severity of the condition? _____

_____

_____

c) How long is this condition likely to persist? _____

_____

2) Describe the symptoms related to the student's condition that cause **significant** impairment in a major life activity.

_____

_____

_____

_____

_____

_____

3) List this student's current medications(s), dosage, frequency, and adverse side effects.

_____

_____

_____

a) Are there any significant limitations to the student's functioning directly related to the prescribed medications?

Yes _____ No _____

If yes, please describe. _____

_____

_____

4) Please state specific recommendations regarding housing, and a rationale as to why these housing needs are warranted based upon the student's medical (physical or emotional health) condition. Indicate why the change(s) to the housing environment you recommend are necessary (e.g., if you suggest a private bathroom state the reasons for this request related to the student's condition).

_____

_____

_____

_____

_____

Please indicate whether any of the following are medically necessary:

- ☐ Service Animal
- ☐ Wheelchair-accessible building
- ☐ Wheelchair-accessible shower
- ☐ Bench seat in shower
- ☐ Bathroom safety bar
- ☐ Strobe fire alarm
- ☐ Other: _____

5) If current treatments (e.g., medications) are successful, why are the above changes to the housing environment necessary?

_____

_____

_____

The provider completing this form cannot be a relative of the student.

Signature of Provider: _____ Date: _____

License #: _____ State: _____

(Please print) Name/Title: _____

Address: _____

Phone: _____