CONNECTICUT COLLEGE

Student Accessibility Services
Asthma and Allergy Verification Form
To Be Completed by Qualified Medical Provider (may not be a relative of student)

Patient Name: _____

DOB: _____ Patient since:_____

Diagnosis/Date of Diagnosis:
(Using either DSM- 5 or ICD Code) _____

This student has been under a provider's care for this issue since: _____

Date the student was last seen by you: _____

Expectation of the duration of impairment/disability: _____

How often is the patient required to be seen by you: _____
(i.e. weekly, monthly, quarterly, yearly, as needed)

Has the student been treated in the emergency room or hospital for this condition in the past year: Date of last hospitalization:

_____ _____

Total number of hospitalizations for this condition: _____

Assessment: **attach relevant test results/reports**
List the Procedures and Evaluations used to make diagnosis:

Major life activities affected in the post-secondary environment:
(Check box in appropriate column for applicable activities)

FUNCTIONAL LIMITATIONS	Mild/Slight	Moderate	Severe
Caring for oneself			
Performing manual tasks			
Seeing			
Hearing			
Breathing			
Sleeping			
Eating			
Standing			
Lifting			
Bending			
Walking			
Speaking			
Learning			
Reading			
Concentrating			
Thinking			
Communicating			
Working			
Operation of a major bodily function			
Other:			

Does the student use and inhaler regularly: _____

Does the student use a Nebulizer regularly: _____

Does the student take prescription medication for this condition:
If yes, please specify the medication, dosage, frequency

What environmental factors exacerbate this condition:

Summarize the present condition and provide the severity of condition: *(mild, moderate, severe, in remission)*

Provide your recommendation for reasonable accommodation(s) for this student and how these accommodations will address specific functional limitations:

State alternatives to meet the documented need if the request cannot be met:

Provider's Signature: _____ Date _____

Provider's Name (print): _____

License/Certification #: _____

Address: _____

City, State, Zip Code: _____

Office Phone #: _____

Return the completed form to sas@conncoll.edu or to the student