

# SPECIAL HOUSING ACCOMMODATION REQUEST

## STUDENT REQUEST (Form A)

This form should be filled out by the student and returned to:

Amanda Bingel  
Office of Residential Life, Union College  
Reamer Campus Center, Room 409

- **Applications submitted late will be considered based on extenuating circumstances and on a case by case basis**
- **Submission of an application does not guarantee that the requested accommodation will be granted**
- **All students must submit Forms A and B; students requesting air conditioners need to submit Forms A, B, and C**
- **Students must make sure that the physician forms are submitted by the application deadline, if submitted separately**

### PLEASE PRINT OR TYPE

Student Name: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

\_\_\_\_\_ Home Phone: \_\_\_\_\_

Incoming Freshman       Transfer Student       Returning Student (Class year \_\_\_\_\_)

**(A) Requests for special housing accommodations will need to be submitted each academic year. The student will be notified in advance if more current documentation is needed each subsequent year a special housing accommodation is requested.** In addition, the College, acting in good faith, reserves the right to request updated documentation at any time.

(B) The student agrees that any information provided in conjunction with this request can be reviewed as necessary by appropriate staff to determine the response. In addition, the student grants permission for attending physicians and/or other professional providers to share information as requested by College staff.  
**REQUESTS WITHOUT STUDENT'S SIGNATURE (BELOW) CANNOT BE CONSIDERED AND WILL BE RETURNED TO THE STUDENT. FORMS WITH INCOMPLETE OR UNCLEAR RESPONSES WILL BE RETURNED TO THE STUDENT.**

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Current housing assignment (if applicable): \_\_\_\_\_

Current housing accommodations (if applicable): \_\_\_\_\_

Housing accommodation(s) requested:

---

---

Why is this accommodation necessary and how it will impact your ability to live in a college residence hall: \_\_\_\_\_

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

During the past school year, have you visited your doctor or the Health Center for treatment due to the disability?

YES \*

NO

\*If yes, please provide number of times and attach documentation (if possible) of your visits.

---

# SPECIAL HOUSING ACCOMMODATION REQUEST

## PHYSICIAN REQUEST (Form B)

### **SECTION I: TO BE COMPLETED BY STUDENT**

Name of Student: \_\_\_\_\_ Union College ID: \_\_\_\_\_

Class Year: \_\_\_\_\_ Email: \_\_\_\_\_

**Consent for Release of Information:** I, \_\_\_\_\_ (student name), give  
\_\_\_\_\_ (physician name) permission to provide the information requested to the  
Committee on Special Accommodations at Union College.

\_\_\_\_\_  
Student signature

\_\_\_\_\_  
Date

### **SECTION II: TO BE COMPLETED BY ATTENDING PHYSICIAN OR SPECIALIST - OFFICE STAMP REQUIRED.**

**\*\*Physician must specialize in the area of the condition or disability, and not be a friend of the family or related to the student by blood or marriage.\*\***

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

License/Certification Number and State of Licensure: \_\_\_\_\_

Are you the primary care physician for this patient: \_\_\_\_\_

Date of most recent office visit: \_\_\_\_\_

How long have you treated this patient? \_\_\_\_\_

<b>Medical diagnosis(es): Please include ICD9-CM OR DSM-IV TR Axis codes</b>		
	Expected Duration:	Prognosis:
Date of:	Permanent, Temporary,	Progressive, Stable,
Diagnosis onset:	Remitting/Relapsing	Guarded

What medications are currently prescribed for this patient?			
Medication:	Dosage:	Daily or PRN:	Side effects experienced by patient (if applicable):

Please indicate the <u>current functional limitations</u> of the patient: (check all that apply).		
Functional limitation:	Effect on functioning:	Degree of limitation:
<input type="checkbox"/> Hearing (include audiogram if applicable)		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Vision (include acuity levels if applicable)		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Speech		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Manual		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Ambulation		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Motor Coordination		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Activities of Daily Living		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Endurance		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Respiratory		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Climatic/Environment		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Concentration		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Memory		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Sleep Disturbance		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Social Interaction		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Eating Disorder		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
<input type="checkbox"/> Other		<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

\*Form adapted from Swarthmore College

Please list any specific accommodations or other services you recommend to address these.

---

---

---

---

---

---

---

---

Please use this space to provide any other information you believe will be helpful to us in assisting your patient in his or her academic endeavors at Union College.

---

---

---

---

---

---

---

---

---

---

---

---

Signature of physician/medical care provider: \_\_\_\_\_

Date: \_\_\_\_\_

Office Stamp: \_\_\_\_\_

**Please return this form to:**    **Union College**  
  **ATTN: Amanda Bingel**  
  **Office of Residential Life, Reamer 409**  
  **807 Union Street**  
  **Schenectady, NY 12308**  
  
  **OR FAX to: 518-388-6694**

\*Form adapted from Swarthmore College

## SPECIAL HOUSING ACCOMMODATION REQUEST

### AIR CONDITIONING REQUEST DUE TO EXTREME MEDICAL CIRCUMSTANCES (Form C)

#### **SECTION I: TO BE COMPLETED BY STUDENT**

Name of Student: \_\_\_\_\_ Union College ID: \_\_\_\_\_

Class Year: \_\_\_\_\_ Email: \_\_\_\_\_

**Consent for Release of Information:** I, \_\_\_\_\_ (student name), give  
\_\_\_\_\_ (physician name) permission to provide the information  
requested to the Committee on Special Accommodations at Union College.

\_\_\_\_\_  
Student signature

\_\_\_\_\_  
Date

#### **SECTION II: TO BE COMPLETED BY ATTENDING ALLERGIST OR MEDICAL SPECIALIST. OFFICE STAMP REQUIRED.**

**\*\*\*Physician must specialize in the area of the condition or disability, and not be a friend of the family or related to the student by blood or marriage.\*\*\***

**Please Note:** Due to the generally mild weather in upstate NY the residence halls are not air conditioned, nor are students permitted to provide air conditioners for their rooms except in rare instances of disability. As part of the standard furniture and room arrangements, student rooms may be carpeted. Students with allergies or asthma generally do okay in this environment without any special arrangements. If allergies or asthma form the basis of a special housing request, full medical documentation will be required including skin test results for allergies. Those students whose conditions are substantially limiting to a major life activity must provide detailed medical documentation to show why the condition qualifies as a disability.

Name: \_\_\_\_\_

Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

License/Certification Number and State of Licensure: \_\_\_\_\_

Date of most recent office visit: \_\_\_\_\_

How long have you treated this patient for an allergic or other significant medical condition?  
\_\_\_\_\_

Type of allergy or significant medical condition:  
\_\_\_\_\_  
\_\_\_\_\_

**Please give the diagnosis, functional limitation, recommendation regarding accommodation needs and your justification for this recommendation on the attached forms.  
(No prescription pad paper please)**

**Section III: ASTHMA**

**(C) Current Diagnosis (select one)**

Exercise Induced Asthma

Intermittent Asthma

Persistent Asthma

Other (please define) \_\_\_\_\_

**(D) Current Asthma Medications (please note medication name, dosage, and how often student takes)**

Short-Acting Beta Agonists

\_\_\_\_\_

Long-Acting Beta Agonists

\_\_\_\_\_

Inhaled Corticosteroids \_\_\_\_\_

Other \_\_\_\_\_

**(E) Please check any of the following which are true for your patient (dates required)**

History of severe asthma exacerbations requiring emergency care (most recent date) \_\_\_\_\_

Prior intubation for asthma

Hospital admission for asthma (most recent hospitalization date) \_\_\_\_\_

Prior office visits for asthma exacerbation (most recent 3 visit dates) \_\_\_\_\_,

\_\_\_\_\_, \_\_\_\_\_

Prior use of IM or oral corticosteroids for asthma (most recent date prescribed) \_\_\_\_\_

Currently requires more than 2 canisters of short-acting beta agonist per month

**(F) Are symptoms: \_\_\_ continuous \_\_\_ intermittent \_\_\_ seasonal \_\_\_ other (please explain below)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(G) Severity of symptoms: \_\_\_ mild \_\_\_ moderate \_\_\_ significant \_\_\_ other (please explain below)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(H) Description of the student's functional limitations or behavioral manifestations in a college residence hall setting:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(I) MEDICAL PROVIDER COMMENTS:** Please list your specific recommendations for reasonable housing accommodations for this student in a college residence hall

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Physician/Medical Care Provider: \_\_\_\_\_

Date: \_\_\_\_\_

**Section III: ALLERGIES**

**(J) Current Diagnosis (select one)**

- Allergic Conjunctivitis
- Allergic Rhinitis (Circle one):      Seasonal      Perennial
- Other (please define):  
\_\_\_\_\_

**10. Current Allergy Medications (please note medication name, dosage, and how often student takes)**

- Antihistamines:  
\_\_\_\_\_
- Steroid Nasal Inhaler:  
\_\_\_\_\_
- Other:  
\_\_\_\_\_

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

- Allergies documented by skin testing or other diagnostic testing (most recent date)  
\_\_\_\_\_
- Prior or current immunotherapy (allergy shots)

**11. Are symptoms:** \_\_\_ continuous    \_\_\_ intermittent    \_\_\_ seasonal    \_\_\_ other  
(please explain below)

**12. Severity of symptoms:** \_\_\_ mild    \_\_\_ moderate    \_\_\_ significant    \_\_\_ other  
(please explain below)

**(K) Description of the student's functional limitations or behavioral manifestations in a college residence hall setting:**

**(L) MEDICAL PROVIDER COMMENTS:** Please list your specific recommendations for reasonable housing accommodations for this student in a college residence hall

Signature of Physician/Medical Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_



## Union College Disability Accommodations Process

Union College provides support services and reasonable accommodation to students with medical and/or psychiatric disabilities who qualify under the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

### Disability and Extreme Medical Condition Housing Accommodations Requests:

1. Requests will be considered on a case by case basis.
2. Students will be notified if they have been approved or denied for housing accommodations after the accommodations committee has met.
3. Submission of an application does not guarantee that the accommodation request(s) will be granted.
4. Special needs housing requires advanced planning and documentation. Student wishing to apply for housing accommodations must complete the appropriate forms, available at the bottom of this page.
5. Students with documented disabilities or extreme medical conditions who are requesting accommodations should meet with either Amanda Bingel (Director of Residential Life) or Shelly Shinebarger (Director of Student Support Services). (A phone call can be scheduled during the summer months)
6. Special needs housing accommodations are intended for individuals with a medical disability, which substantially limits their ability to function daily in a residence hall environment.
7. There is a difference between housing accommodations and housing preferences. Student preferences for certain types of housing (ground floor, air conditioning, etc.) cannot be granted, whereas reasonable accommodations are provided to student with documented disabilities.

### Documentation Forms:

- Form A: (to be completed by student) [all requests]
- Form B: (to be completed by physician) [all requests]
- Form C: (to be completed by specialist) [all requests]\*

\*All students must submit Forms A and B. Students requesting air conditioning must ALSO submit Form C.

Students approved for air conditioning due to extreme medical conditions may be required to:

If not housed in College Park Hall:

- Provide their own air conditioning unit (Facilities Services will provide specifications)
- Contact Facilities Services through the online work request system to install the air conditioning unit. Students may not install their own unit and must schedule installation with a qualified staff member. We cannot guarantee that your air conditioning unit will be installed on the first day you arrive to campus. Every effort will be made to install units within the first 1-2 weeks of classes.

**\*\*Please note:** due to the generally mild climate in Schenectady, NY the residence halls (with the exception of College Park Hall) are not air conditioned, nor are students permitted to provide air conditioning units for their rooms except in the rare instances of disability. As part of the standard furniture and room arrangements, some student rooms are carpeted. Students with allergies or asthma

generally do well in this environment without any special arrangements. If allergies or asthma form the basis of a special housing request, full medical documentation will be required, including skin test results for allergies. Those students whose conditions are substantially limiting to a major life activity must provide detailed medical documentation to show why the condition qualifies as a disability.