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): _________________________________________

*Form adapted from Swarthmore College
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? _____________________________________________

Medical diagnosis(es): Please include ICD9-CM OR DSM-IV TR Axis codes

<table>
<thead>
<tr>
<th>Medical diagnosis(es)</th>
<th>Expected Duration</th>
<th>Prognosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of:</td>
<td>Permanent, Temporary,</td>
<td>Progressive, Stable,</td>
</tr>
<tr>
<td>Diagnosis onset:</td>
<td>Remitting/Relapsing</td>
<td>Guarded</td>
</tr>
</tbody>
</table>

*Form adapted from Swarthmore College*
### What medications are currently prescribed for this patient?

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Daily or PRN</th>
<th>Side effects experienced by patient (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Please indicate the current functional limitations of the patient: (check all that apply).

<table>
<thead>
<tr>
<th>Functional limitation:</th>
<th>Effect on functioning:</th>
<th>Degree of limitation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Hearing (include audiogram if applicable)</td>
<td>□Mild □Moderate □Severe</td>
<td></td>
</tr>
<tr>
<td>□ Vision (include acuity levels if applicable)</td>
<td>□Mild □Moderate □Severe</td>
<td></td>
</tr>
<tr>
<td>□ Speech</td>
<td>□Mild □Moderate □Severe</td>
<td></td>
</tr>
<tr>
<td>□ Manual</td>
<td>□Mild □Moderate □Severe</td>
<td></td>
</tr>
<tr>
<td>□ Ambulation</td>
<td>□Mild □Moderate □Severe</td>
<td></td>
</tr>
<tr>
<td>□ Motor Coordination</td>
<td>□Mild □Moderate □Severe</td>
<td></td>
</tr>
<tr>
<td>□ Activities of Daily Living</td>
<td>□Mild □Moderate □Severe</td>
<td></td>
</tr>
<tr>
<td>□ Endurance</td>
<td>□Mild □Moderate □Severe</td>
<td></td>
</tr>
<tr>
<td>□ Respiratory</td>
<td>□Mild □Moderate □Severe</td>
<td></td>
</tr>
<tr>
<td>□ Climatic/Environment</td>
<td>□Mild □Moderate □Severe</td>
<td></td>
</tr>
<tr>
<td>□ Concentration</td>
<td>□Mild □Moderate □Severe</td>
<td></td>
</tr>
<tr>
<td>□ Memory</td>
<td>□Mild □Moderate □Severe</td>
<td></td>
</tr>
<tr>
<td>□ Sleep Disturbance</td>
<td>□Mild □Moderate □Severe</td>
<td></td>
</tr>
<tr>
<td>□ Social Interaction</td>
<td>□Mild □Moderate □Severe</td>
<td></td>
</tr>
<tr>
<td>□ Eating Disorder</td>
<td>□Mild □Moderate □Severe</td>
<td></td>
</tr>
<tr>
<td>□ Other</td>
<td>□Mild □Moderate □Severe</td>
<td></td>
</tr>
</tbody>
</table>

*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
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)

*Form adapted from Swarthmore College
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: ________________

*Form adapted from Swarthmore College
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

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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.

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