WESLEYAN
STUDENT AFFAIRS
Student Academic Resources

Verification of Disability Form for Asthma and Allergy Conditions

Dear Provider:

Your patient, _____, has indicated that s/he has asthma or allergies that rise to the level of disability and will require reasonable accommodations to participate in a program or activity (including housing) at Wesleyan University. The Accessibility Services office coordinates reasonable accommodations, modifications, and auxiliary aids and services for students with disabilities in accordance with Section 504 of the Rehabilitation Act of 1973, and with the Americans with Disabilities Act of 1990 as amended in 2008, as well as other applicable state and federal laws.

Individuals requesting accommodations must disclose the nature of their impairment and provide documentation that verifies their current level of functioning. In order for a student to be considered eligible to receive accommodations, documentation must show functional limitations that substantially impact the individual. You have been asked to complete this form as documentation for your client. All information provided to us is kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).

Please take the time to complete this form in its entirety. The information you provide will be used to determine the nature and severity of the student's condition and the appropriateness of requested accommodations or services. Submit this form and any supplemental documentation to Accessibility Services at accessibility@wesleyan.edu, or via fax (860.685.4480), or send via mail to:

Wesleyan University, North College 021
237 High Street
Middletown, CT 06459

If you have any questions about this form or the accommodation process, please contact Accessibility Services. This form can also be completed electronically by downloading the fillable PDF form available on our website: http://www.wesleyan.edu/studentaffairs/disabilities/providers.html

Student Name: _____ Date of last visit for this condition: _____

Diagnosis: _____ Date of Diagnosis: _____

Procedures/assessments used to diagnose this student's condition (Please attach copy of test results; eg: allergy testing, pulmonary function testing, etc.): _____

Severity of the condition (check one): ☐ Mild ☐ Moderate ☐ Substantial ☐ In Remission

Has the student been treated in a hospital or ER for this condition in the past year? ☐ Yes ☐ No

Total number of hospitalizations related to this condition: _____

Date of last hospitalization: _____

What environmental factors exacerbate this condition? _____

Does the student take prescription medication for this condition? ☐ Yes ☐ No
If yes, please specify:

Medication	Dosage	Frequency

Does the student use a prescribed inhaler regularly? ☐ Yes ☐ No

What are the functional limitations caused by this condition and/or its treatment? _____

Recommended accommodations (must be clearly linked to the identified functional limitations): _____

Anticipated duration of need for accommodation: _____

I understand that the information provided will become part of the student record subject to the Federal Family Education Rights and Privacy Act of 1974 and may be released to the student on their written request.

Name of Medical Professional (Print): _____

Title: _____

License/Certification #: _____ State of License/Certification: _____

Address: _____

Phone: _____ Fax Number: _____

Email Address: _____

Signature: _____ Date: _____
(*Verifying that you are not related to the student by blood or marriage)*

Wesleyan University Accessibility Services, North College-Room 021, 237 High Street, Middletown, CT 06459
Phone: 860-685-5581 Fax: 860-685-4480