STUDENT ACCESSIBILITY SERVICES
ST. CLOUD STATE UNIVERSITY
202 Centennial Hall – 720 Fourth Avenue South – St. Cloud, MN 56301-4498

Health Care Form for Students Requesting Housing Accommodations

In order to evaluate how we can best meet your needs, we require specific information from both you and your examiner. You must complete the top portion of the form below. Also, to facilitate the process, we need you to fill out and sign the Authorization to Receive Health Care Information below. This gives us permission to speak with your examiner if we have questions relating to his/her recommendation for accommodations(s). Your health care provider must complete the rest of this form, sign it, and return the completed packet to the above address.

Student Fills Out This Section

Student Name: _____

(Last) (First) (Middle)

SCSU Tech ID Number: _____

Birth Date: _____ Gender: ___ Male ___ Female

First Semester Enrolled at SCSU _____

Home Address: _____

Home Phone #: _____

Local Address: _____

Local Phone #: _____ E-Mail Address: _____

AUTHORIZATION TO RECEIVE INFORMATION: I authorize:

- The Accessibility Services Director to receive information from the provider below.
- My provider to discuss my condition (s) with the Accessibility Services Director.
- The Accessibility Services Director to discuss my condition with the Director of Residential Life or his/her designee.

Name of Provider: _____

Address (Street, City, State, and zip): _____

_____

Student's Signature: _____ Date:_____

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

STUDENT'S NAME: _____

Provider Completes the Section Below:
St. Cloud State University provides accommodations and support services to students with diagnosed disabilities. A student's documentation regarding their condition must demonstrate they have a disability covered under the Americans with Disabilities Act (ADA: 1990). ***The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.** To determine eligibility for services and accommodations, this office requires current and comprehensive documentation of the student's disorder from the diagnosing physician or health care provider (the provider completing this form cannot be a relative of the student). Items 1 thru 6 must be completed in full. If 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 last?
      _____
      _____
2. Describe the symptoms related to the student's condition that cause significant impairment in a major life activity.
   _____
   _____
   _____
   _____
3. List the student's current medications(s), dosage, frequency, and adverse side effects.
   _____
   a. Are there significant limitations to the student's functioning directly related to the prescribed medications? Yes _____ No _____
   b. If yes, please describe.
      _____

4. Does the student have a disability as a result of this condition? ___ Yes ___ No

5. If yes, please state specific recommendations regarding housing accommodations for this student, and a rationale as to why these housing accommodations are warranted based upon the student's functional limitations. Indicate why the housing accommodations you recommend are necessary (e.g. if you suggest a private room state the reasons for this request related to the student's disability).
   _____
   _____
   _____
   _____
   _____

6. If the student is requesting an Emotional Support Animal (ESA), is this an animal that you specifically prescribed as part of treatment for the student, or is it a pet that you believe will have a beneficial effect for the student while in residence on campus? ___ Yes ___ No

   a. If yes, please describe.
      _____
      _____
      _____

7. If current treatments (e.g. medications) are successful, why are the above housing accommodations necessary?
   _____
   _____

The provider may also send a report that provides additional related information.

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

Signature of Provider: _____ Date: _____

License # _____ State _____

(Please Print) Name/Title: _____

Address: _____

Phone: _____

Please mail to the address above or fax to 320-308-5100.

It is imperative we receive verification of the provider's authenticity. All documentation must include an official clinic stamp, original letterhead and/or fax cover sheet.