Accessibility Services
Southwest Minnesota State University
1501 State Street, IL 220, Marshall, MN 56258
Phone: 507-537-6492 Fax: 507-537-6812

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)

SMSU Student ID Number _____

Birth Date: _____ Gender: ☐ Male ☐ Female _____Other

First Semester Enrolled at Southwest Minnesota State University _____

Home Address: _____

Home Phone #: _____

Local Address: _____

Local Phone #: _____ E-Mail Address: _____

AUTHORIZATION TO RECEIVE INFORMATION: I authorize:

- The Disability Services Director or designee to receive information from the provider below.
- My provider to discuss my condition (s) with the Disability Services Director or designee
- The Accessibility Services Director or designee 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:

Southwest Minnesota 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 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 or fax the above information to the address/number listed above. Do not email this filled out form.

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.