THE UNIVERSITY OF CHICAGO

Campus & Student Life
Student Disability Services

5501 South Ellis Avenue, Chicago, IL 60637 • 773.702.6000 • disabilities@uchicago.edu

Medical Conditions Verification Form

This form is to be completed by a certified health professional for a University of Chicago student.

Student Disability Services (SDS) provides services and accommodations to persons with disabilities to ensure **equal access and opportunity to educational programs and activities**. Current disability documentation is used to verify that a diagnosed condition meets the legal definition of a disability covered under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Act as amended in 2008. These laws define a disability as a physical or mental impairment that substantially limits one or more major life activities. Eligibility for disability services is based, in part, on documentation that clearly demonstrates that the student has one or more functional limitations. An SDS director meets with each student to discuss their access needs and requests. It is our goal to ensure equal access to our programs and services.

Please return the completed form to:
University of Chicago, Student Disability Services
5501 South Ellis Avenue
Chicago, IL 60637
E-mail: disabilities@uchicago.edu
Fax: 773-926-0996

Student Consent

I, ____, authorize my healthcare professional named below to release to Student Disability Services the medical information requested on this form for the purpose of determining appropriate accommodation for my disability while a student at the University of Chicago.

Signature of student: ____________________________________ Date: ___________

If signed by person other than student, state relationship and authority to do so:

____

Expiration Date: ___________________

Certifier Information

Clinician name: ____

Clinician signature: ____

Medical specialty: ____

License/Certification number: ______________________ Issuing state: ______________

Phone: _________________ Clinician e-mail address: ___________________________

Street address or website of practice: _______________________________________

Date of completion of form: ____________________ Expiration date: ________________

Patient Information

Date of initial contact with patient: ____

Date of most recent contact with patient: ____________________________________

Approximate frequency of contact with patient since initial contact: __________________

Describe the patient's condition, listing a specific diagnosis (if applicable). Include the date the diagnosis was determined and explain the tests and/or diagnostic methods used to determine the diagnosis.

Is this a temporary or permanent condition?_____________________________________

Describe the functional impairments resulting from this condition (e.g., physical, cognitive, perceptual abilities).

Describe any current and/or anticipated impact of the condition in an academic setting (e.g., headaches caused by computer glare, fatigue) or living environment (e.g., requirement for a controlled environment).

Indicate the level of severity of the condition (select one):

☐ Mild
☐ Moderate
☐ Severe

Describe the impact of the condition on performing tasks of daily living (e.g., unable to walk more than 50 feet, unable to drive).

Is the patient taking any medication? If yes, what effect does the medication have mitigating the symptoms of the condition? Are there any side effects the patient experiences?

If the patient is undergoing treatment, please describe how the treatment may affect the impact of the condition and/or result in side effects that will impact the patient in an academic or living setting.

Please offer any recommendations for reasonable academic or living adjustments and/or accommodations based on your assessment of areas of functional impairment that will support equal access to UChicago programs and services. *Note: This information will be taken into consideration by the SDS staff in determining reasonable accommodations under federal disability laws.*

Please provide any additional information that you think will be useful in evaluating the nature and severity of your patient's disability that will inform the determination of eligibility for disability services and accommodations.

Allergy and Asthma Conditions

Please complete this section if it applies to the patient. If it does not apply, please leave blank.

Procedures/assessments used to diagnose (select all that apply):

- ☐ Spirometry
- ☐ Allergy Testing
- ☐ Evaluation by allergy/asthma specialist
- ☐ Other (please explain):____

Check the following that apply to this patient (select all that apply):

- ☐ Was treated in the emergency room for this condition within the last year.
- ☐ Has received in-patient treatment (i.e., hospitalization) for this condition within the last year.
- ☐ Prescribed allergy shots
- ☐ Prescribed short-acting rescue inhaler
- ☐ Uses an epinephrine pen (i.e., Epi-pen)
- ☐ Recommended to use oral maintenance medications (including antihistamines, leukotriene inhibitors)
- ☐ Prescribed inhaled maintenance medications (including steroids, combined beta-agonists)

Environmental and Food Allergies

Please list diagnosed allergens that are relevant to the classroom, housing, and/or dining environments (e.g., tree nuts, cleaning products, dust).

The following exposures trigger a food allergy reaction (select all that apply):

- ☐ Not applicable
- ☐ Airborne particles
- ☐ Skin contact
- ☐ Ingestion
- ☐ Cross-contact
- ☐ Other (please explain):____

The food allergy triggers the following reaction (select all that apply):

- ☐ Not applicable
- ☐ Anaphylaxis
- ☐ Angioedema
- ☐ Rash
- ☐ Gastrointestinal symptoms
- ☐ Other (please explain):____

Please list your recommendations to the patient for allergy management.

Asthma Conditions

Please indicate the severity of the patient’s asthma condition (select one):

- ☐ Mild intermittent
- ☐ Moderate persistent
- ☐ Severe persistent

What specifically induces asthma for this patient?

Please list your recommendations to the patient for asthma management.