

Medical Request - Use of an Air Conditioner

Part 1: Student Information (Completed b	by Student)	
Full Name (Last, First, Middle Initial)	GCC ID#	Anticipated Graduation Date (Semester & Year)
Applicant (Student) Signature		Date
By signing this form, the individual named release the enclosed information to the Di authorizing his or her medical provider to Disability Services Office should clarificat remain valid for one year from the date of	sability Services Offic discuss this informati ion or more informati	ce at Grove City College and is on with a representative of the on be necessary. This release will
Part 2: Disability Information (Completed	l by Medical Provide	r)
The responding provider must be an objecti within his or her scope of practice. General Primary Care Physician, Allergist, Pulmonol	ly, the responding pro	ovider must be one of the following:
Provider Name (Print)	Pı	rovider Specialty
License Number	Is	suing State
Address	Pl	hone Number
Provider Signature	D	ate



Your patient has requested the use of an air conditioner in his or her college housing location. Grove City College has limited ability to permit air conditioners due to their electrical demand, but we do our best to accommodate individuals who have a medical condition that warrants the need for an air conditioner. Please provide as much detail as possible so we can have a better understanding of why an air conditioner is necessary for your patient to have equal access.

1.	What is the student's diagnosis that warrants the use of an air conditioner?
2.	Did you diagnose the individual with this condition(s)?YesNo
3.	Date of initial diagnosis: Date of most recent follow-up:
4.	How will the use of an air conditioner mitigate symptoms? Note: Generally, a statement that "The A/C reduces symptoms of diagnosis" is too general and does not explain how the A/C may alleviate the symptoms of this student's disability.
5.	Is the condition intermittent or seasonal in nature?YesNo If Yes, when, and how often is your patient affected?
6.	What is the expected duration of the condition?
	WeeksMonthsPermanentOther
7.	Can an air purifier or fan be substituted for an air conditioner?YesNo If No, explanation required:

Note: Federal law defines a person with a disability as someone who has a physical or mental impairment that **substantially limits** one or more major life activities. That suggests that a diagnosis (label) does not necessarily equate with a disability (substantial limitation).

Please complete the subsection(s) relevant to your patient on the following page(s).



Asthma

Α.	Curren	nt diagnosis (select one):		
	a.	Exercise-induced Asthma		
	b.	Intermittent Asthma		
	c.	Persistent Asthma		
	d.	Other (please describe):		_
В.	Curren	t Asthma Medication		
	a.	Short-acting Beta Agonists		
		Medication:	Dosage:	
	b.	Long-acting Beta Agonists		
		Medication:	Dosage:	
	c.	Inhaled Corticosteroids		
		Medication:	Dosage:	
	d.	Other		
		Medication:	Dosage:	
C.	Please	check any of the following which are true for your pati	ient (dates required):	
C.		check any of the following which are true for your pati History of severe asthma exacerbations requiring em	, , , , , , , , , , , , , , , , , , , ,	
C.		check any of the following which are true for your pati History of severe asthma exacerbations requiring em	, , , , , , , , , , , , , , , , , , , ,	
C.		History of severe asthma exacerbations requiring em	, , , , , , , , , , , , , , , , , , , ,	
C.			, , , , , , , , , , , , , , , , , , , ,	
C.	a.	History of severe asthma exacerbations requiring em	, , , , , , , , , , , , , , , , , , , ,	
C.	a.	History of severe asthma exacerbations requiring em Date(s):	, , , , , , , , , , , , , , , , , , , ,	
C.	a.	History of severe asthma exacerbations requiring em Date(s):	, , , , , , , , , , , , , , , , , , , ,	
C.	a.	History of severe asthma exacerbations requiring em Date(s): Prior intubation for asthma.	, , , , , , , , , , , , , , , , , , , ,	
C.	a. b.	History of severe asthma exacerbations requiring em Date(s): Prior intubation for asthma.	, , , , , , , , , , , , , , , , , , , ,	
C.	a. b.	History of severe asthma exacerbations requiring em Date(s): Prior intubation for asthma. Date(s):	, , , , , , , , , , , , , , , , , , , ,	
C.	a. b.	History of severe asthma exacerbations requiring em Date(s): Prior intubation for asthma. Date(s):	, , , , , , , , , , , , , , , , , , , ,	
C.	b.	History of severe asthma exacerbations requiring em Date(s): Prior intubation for asthma. Date(s): Hospital admission for asthma. Date(s):	, , , , , , , , , , , , , , , , , , , ,	
C.	b.	History of severe asthma exacerbations requiring em Date(s): Prior intubation for asthma. Date(s): Hospital admission for asthma.	, , , , , , , , , , , , , , , , , , , ,	
C.	b.	History of severe asthma exacerbations requiring em Date(s): Prior intubation for asthma. Date(s): Hospital admission for asthma. Date(s): Prior office visits for asthma exacerbation.	, , , , , , , , , , , , , , , , , , , ,	
C.	b.	History of severe asthma exacerbations requiring em Date(s): Prior intubation for asthma. Date(s): Hospital admission for asthma. Date(s):	, , , , , , , , , , , , , , , , , , , ,	
C.	a. b. c.	History of severe asthma exacerbations requiring em Date(s): Prior intubation for asthma. Date(s): Hospital admission for asthma. Date(s): Prior office visits for asthma exacerbation. Date(s):	, , , , , , , , , , , , , , , , , , , ,	
C.	b.	History of severe asthma exacerbations requiring em Date(s): Prior intubation for asthma. Date(s): Hospital admission for asthma. Date(s): Prior office visits for asthma exacerbation.	, , , , , , , , , , , , , , , , , , , ,	
C.	a. b. c.	History of severe asthma exacerbations requiring em Date(s): Prior intubation for asthma. Date(s): Hospital admission for asthma. Date(s): Prior office visits for asthma exacerbation. Date(s):	, , , , , , , , , , , , , , , , , , , ,	

f. Currently requires more than 2 canisters of short-acting beta agonist per month.



D.	Are syr	nptoms:	contin	uous	inte	rmittent	seasonal	other (please explain)
E.	Severit	y of sympt	toms:	mild	mod	derate	severe	other (please explain)
Aller	gies							
A.	a. b.	Allergic C	hinitis (Conjunc				Perennial	
В.		t Allergy M		ons				
	a.	Antihista				Doogo		Frequency:
	b.	Medication: Dosage: Steroid nasal inhaler						riequelicy.
	٥.	Medicat				Dosage:		Frequency:
	C.	Other						
		Medicat	ion:			Dosage:		Frequency:
C.		_		_		-	our patient (da	• •
	a.			ented by skin			diagnostic tes	ting:
	b.	Prior or c	urrent i	mmunothera	py (al	llergy shot	s):	
		Date(s): _						
	C.	Other:						
		Date(s): _						
D.	Are syr	nptoms:	contin	uous	inte	rmittent	seasonal	other (please explain)
E.	Severit	y of sympt	toms:	mild	mod	derate	severe	other (please explain)



A. Current Diagnosis:

Disability Services
Henry Buhl Library
Grove City college
100 Campus Drive
Grove City, PA 16127
DisabilityServices@gcc.edu

Migraines

	a.	Chronic Migraines							
	b.	Migraines with Aura							
	c.	Migraines without Aura							
	d.	Vestibular Migraines							
	e.	Other (please describe):							
В.	Curren	nt Medications							
	a.	Acute Medication(s):							
		Medication:	Dosage:	Frequency:					
	b.	Preventative Medication(s):							
		Medication:	Dosage:	Frequency:					
	c.	Nausea Medication(s):							
		Medication:	Dosage:	Frequency:					
_	Diana			+ · · · · · · · · · · · · · · · · ·					
C.		check any of the following which		tes required):					
	a.	Prior office visits for migraine exa	icerpation.						
		Date(s):							
		Date(s)							
	b.	History of severe migraine exace	rhation requiring urgent or a	amergency care					
	Б.	Thistory of Severe inigranic exace	ibation requiring digent of t	omergency care.					
		Date(s):							
		Dato(0).	 						
	C.	Hospital admission for migraine	exacerhation and/or migrai	ne exacerbation with					
	٥.	additional symptomology.	oxacorbation and or imprai	no exacerbation man					
		a.a.a.a.a.a,p.coc.c.g,.							
		Date(s):							
		()							
D.	Are syr	nptoms: continuous in	termittent seasonal	other (please explain)					
	_			,					
E.	Severit	y of symptoms: mild m	oderate severe	other (please explain)					

All information included in this document will be considered. Accommodation decisions are based upon the nature of the disability and functional limitations, reasonableness of the request, available housing configurations, and timing of the request. Potential alternatives to the requested housing accommodation may be considered and recommended, as needed.