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

Medical Request – Use of an Air Conditioner

This form must be completed in full and submitted for review to the Disability Services Office.

Student completes this section: Anticipated Year of Graduation: _____

_____ GCC ID # _____
First Name M.I. Last Name

_____ _____
Applicant's Signature Date

Physician completes this section: The responding physician must be one of the following: Primary Care Physician, Allergist, Pulmonologist or Ear, Nose and Throat Physician.

Your patient has requested the use of an air conditioner in their university 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. What is the nature of the patient's condition? Please provide as much detail as possible so we can have a better understanding of your patient's condition.

1. What is the student's diagnosis that warrants the use of an air conditioner?

2. How will the use of an air conditioner mitigate symptoms?

3. Is the condition intermittent or seasonal in nature? _____Yes _____No
   If Yes, when, and how often is your patient affected?

4. What is the expected duration of the condition?
   _____Weeks _____Months _____Permanent _____Other

5. Can an air purifier or fan be substituted for an air conditioner? _____Yes _____No
   If No, Please Explain:

_____ _____
Physician's Name (Please print) Signature

_____ _____
Physician's Specialty Date

_____
Physician's Office Phone #

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1.**ASTHMA**

A. Current diagnosis (select one):

- ☐ Exercise induced Asthma
- ☐ Intermittent Asthma
- ☐ Persistent Asthma
- ☐ Other (please define): _____

B. Current Asthma Medications (please note medication(s) name and dosage):

	Medication Name	**Dosage**
☐ Short-acting Beta Agonists		
☐ Long-Acting Beta Agonists		
☐ Inhaled corticosteroids		
☐ Other		

C. Please check any of the following which are true for your patient (dates required):

- ☐ History of severe asthma exacerbations requiring emergency care _____
- ☐ Prior intubation for asthma _____
- ☐ Hospital admission for asthma _____
- ☐ Prior office visits for asthma exacerbation _____
- ☐ Prior use of IM or oral corticosteroids for asthma _____

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

D. Are symptoms: continuous intermittent seasonal other (please explain):

E. Severity of symptoms: mild moderate significant other (please explain):

___ 10. **ALLERGIES**

A. Current Diagnosis:

- ☐ Allergic Rhinitis (circle one): *Seasonal* *Perennial*
- ☐ Allergic conjunctivitis
- ☐ Other: explain _____

B. Current Allergy medications (including medication name and frequency of daily use):

	Medication Name	**Dosage**
☐ Antihistamines		
☐ Steroid nasal inhaler		
☐ Other		

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C. Please check any of the following which are true for your patient (dates required):

- ☐ Allergies documented by skin testing or other diagnostic testing: Date _____
- ☐ Prior or current immunotherapy (allergy shots): Date_____
- ☐ Other:_____ Date_____

D. Are symptoms:____continuous____intermittent_____seasonal_____other (please explain):

E. Severity of symptoms:_____mild moderate_____significant____other (please explain):