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

Part 1: Student Information (Completed 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 above is authorizing his or her medical provider to release the enclosed information to the Disability Services Office at Grove City College and is authorizing his or her medical provider to discuss this information with a representative of the Disability Services Office should clarification or more information be necessary. This release will remain valid for **one year** from the date of the individual's signature above.

Part 2: Disability Information (Completed by Medical Provider)

The responding provider must be an objective, licensed medical provider providing information within his or her scope of practice. Generally, the responding provider must be one of the following: Primary Care Physician, Allergist, Pulmonologist, Neurologist, or Ear, Nose, and Throat Physician.

Provider Name (Print)	Provider Specialty

License Number	Issuing State

Address	Phone Number

Provider Signature	Date

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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 condition that warrants the use of an air conditioner?

2. Did you diagnose the individual with this condition(s)? _____Yes _____No

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. Can an air purifier or fan be substituted for an air conditioner? _____Yes _____No
   If no, explanation required:

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

7. What is the expected duration of the condition?

   _____Weeks _____Months _____Permanent _____Other

8. Is there a negative health impact that may be permanent if the request is not met?
   If yes, explanation required:

9. Is the impact of the condition life threatening if the request is not met?

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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

A. Current diagnosis (select one):
   a. Exercise-induced Asthma
   b. Intermittent Asthma
   c. Persistent Asthma
   d. Other (please describe): _____

B. Current 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 patient (dates required):
   a. History of severe asthma exacerbations requiring emergency care.

      Date(s): _____

   b. Prior intubation for asthma.

      Date(s): _____

   c. Hospital admission for asthma.

      Date(s): _____

   d. Prior office visits for asthma exacerbation.

      Date(s): _____

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e. Prior use of IM or oral corticosteroids for asthma.

Date(s): _____

f. 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 severe other (please explain)

Allergies

A. Current Diagnosis:
   a. Allergic Rhinitis (circle one): Seasonal Perennial
   b. Allergic Conjunctivitis
   c. Other (please explain): _____

B. Current Allergy Medications
   a. Antihistamines

Medication:	Dosage:	Frequency:

   b. Steroid nasal inhaler

Medication:	Dosage:	Frequency:

   c. Other

Medication:	Dosage:	Frequency:

C. Please check any of the following which are true for your patient (dates required):
   a. Allergies documented by skin testing or other diagnostic testing:

   Date(s): _____

   b. Prior or current immunotherapy (allergy shots):

   Date(s): _____

   c. Other:

   Date(s): _____

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

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

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Migraines

A. Current Diagnosis:
   a. Chronic Migraines
   b. Migraines with Aura
   c. Migraines without Aura
   d. Vestibular Migraines
   e. Other (please describe): _____

B. Current Medications
   a. Acute Medication(s):

Medication:	Dosage:	Frequency:

   b. Preventative Medication(s):

Medication:	Dosage:	Frequency:

   c. Nausea Medication(s):

Medication:	Dosage:	Frequency:

C. Please check any of the following which are true for your patient (dates required):
   a. Prior office visits for migraine exacerbation.

      Date(s): _____

   b. History of severe migraine exacerbation requiring urgent or emergency care.

      Date(s): _____

   c. Hospital admission for migraine exacerbation and/or migraine exacerbation with additional symptomology.

      Date(s): _____

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

E. Severity of symptoms: mild moderate 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.