



Department of Counseling and Disability Services  
7373 Admiral Peary Highway  
Cresson PA 16630-1999

www.mtaloy.edu  
(814) 886-6336  
Fax: (814) 886-6575

## Verification of Disability Form for Asthma and Allergy Conditions

(Please print)

**Purpose:** The student named below has indicated that s/he has asthma or allergies that rise to the level of disability and will require reasonable accommodations to participate in a program or activity (including housing and meal plans) at Mount Aloysius College. The information you provide will be used to determine the nature and severity of the student's condition and the appropriateness of requested accommodations or services.

Please take the time to complete this form in its entirety. **Contact the Department of Disability Services at (814) 886-6515 with any questions.** All information provided to us is kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA). A signed consent for release of information should be completed by the student prior to the release of this form. Thank you for your assistance. **Return completed form and documentation to: Department of Counseling and Disability Services, Mount Aloysius College, 7373 Admiral Peary Highway, Cresson, PA 16630**

Student Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_

Date of last visit for this condition: \_\_\_\_\_

Procedures/assessments used to diagnose this student's condition (Please attach a copy of test results; eg: allergy testing, pulmonary function testing, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Severity of the condition (circle one):    Mild        Moderate        Severe        In Remission

Has the student been treated in an emergency room or hospital for this condition with the last year? YES    NO

Total number of hospitalizations related to this condition: \_\_\_\_\_

Date of last hospitalization: \_\_\_\_\_

What environmental factors exacerbate this condition? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Does the student take prescription medication for this condition? YES    NO

If yes, please specify medications, dosage and frequency:

Medication	Dosage	Frequency

Does the student use a prescribed inhaler regularly?      YES      NO

**What are the functional limitations caused by this condition and/or its treatment?** \_\_\_\_\_

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**Recommended accommodation** (must be clearly linked to functional limitations):

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Anticipated duration of need for accommodation: \_\_\_\_\_

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**Name of Medical Professional:** \_\_\_\_\_

**License #:** \_\_\_\_\_

**Please indicate State:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Signature:** \_\_\_\_\_      **Date** \_\_\_\_\_