LAFAYETTE COLLEGE

Air Conditioning Request Form

Air conditioning in Lafayette College's residence halls is limited and students are not permitted to have air conditioners installed in their room except in rare cases of a documented medical condition or disability. In order to evaluate a student's request for air conditioning, the College requires specific diagnostic information from a licensed health care provider or clinical professional. This physician/clinician must be familiar with the functional limitations of the student's medical condition(s). The **student** must complete Section I of the form. By completing Section I, the student consents to allow their physician/clinician to provide information regarding the student's medical condition to the College, and allows appropriate and qualified staff members to discuss the student's request, condition, and resulting determination with the physician/clinician filling out this form. If multiple physicians/clinicians need to provide information, please fill out multiple forms.

The physician/clinician must fill out Sections II and III, attach any supporting documentation, and return the completed packet via mail, fax, and/or email to:

Bailey Health Center
607 High Street
Easton, PA 18042

Phone: 610-330-5001
Fax: 610-330-5704
Email: goldstej@lafayette.edu

SECTION I – *TO BE COMPLETED BY THE STUDENT*

Name: ____ Anticipated Year of Graduation _______
First M.I. Last

I hereby give ____ (healthcare provider's name) permission to provide the information requested below to Accessibility Services at Lafayette College.

____ ____________________
Student Signature (or legal guardian if under 18 years of age) Date

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SECTION II – *TO BE COMPLETED BY THE HEALTHCARE PROVIDER MANAGING THE MEDICAL CONDITION GIVING RISE TO THIS REQUEST FOR AIR CONDITIONING.*

Important: Many of the residence halls at Lafayette College are not air conditioned, nor are students permitted to have air conditioners installed in their rooms except in rare instances of medical condition or disability. If allergies and/or asthma form the basis of this special housing request, full medical documentation must be provided.

Name of Healthcare Provider: _________________________________ Specialty: ________________________

Address: ____

City: ___________________________ State: _____________________ Zip: ______________________

Date of most recent office visit by student: ____

How long have you treated this patient for the medical condition giving rise to this request? _______________

Type of medical condition giving rise to this request for an air conditioned dormitory room: ________________

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Please provide the student's diagnosis, functional limitation(s), confirmation of your recommendation for air conditioning, and your justification for your recommendation on page 2 of this form.

SECTION III –*TO BE COMPLETED BY THE HEALTHCARE PROVIDER MANAGING THE MEDICAL CONDITION GIVING RISE TO THIS REQUEST FOR AIR CONDITIONING.*

1. Diagnosis (*list all relevant diagnoses*): ______________________________

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2. Please describe all diagnostic methodology you utilized to arrive at the diagnosis.

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For **allergy** patients: Has the student been skin tested by an allergy specialist?

☐ Yes (*please fax results to the Bailey Health Center*)

☐ No

For **asthma** patients: Has the student undergone a pulmonary function test?

☐ Yes (*please fax results to the Bailey Health Center*)

☐ No

3. Current treatment being received by the student:

☐ Medication (*please specify*) ______________________________

☐ Other (*please specify*) ______________________________

4. Are symptoms: ☐ Continuous ☐ Intermittent ☐ Seasonal

Other (*please explain*): ______________________________

5. Severity of symptoms: ☐ Mild ☐ Moderate ☐ Severe

Other (*please explain*): ______________________________

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6. Please describe the student's functional limitations based on the diagnosis ______________________________

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7. Is there another device that may be substituted for an air conditioner, such as an air purifier or fan?

☐ Yes (*please explain*) ______________________________

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☐ No (*please explain*) ______________________________

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The information provided above is true and accurate:

______________________________ ______________________________

Signature of Healthcare Provider Date

______________________________ ______________________________

License Number State