



Verification of a Disability for Asthma and Allergy Conditions

Student Disability Services at Cornell University provides services and accommodations to persons with disabilities to ensure equal access to educational programs and activities. A disability must **substantially limit** one or more major life activity, such as walking, seeing, hearing, speaking, breathing, learning, caring for one's self, performing manual tasks, and working. Current and comprehensive disability documentation from a health-care provider (who is not a relative of the student) is required to assist with the provision of appropriate and reasonable accommodations and/or auxiliary aids. Additional documentation may be required.

To be completed by a certified health care professional.

All items are required. Please print legibly. Include additional pages, if needed.

Physician's Name: _____ Today's Date: _____
Address: _____

License/Cert: #: _____ Phone: _____ Fax: _____

Student's Name: _____ Date of Birth: _____

Complete Diagnosis: _____

Date of Diagnosis: _____ Date of last visit to health care provider for this condition: _____

Procedures/assessments used to diagnose this student's condition: _____

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

Does the student use a prescribed inhaler regularly? Yes No

Does the student take prescription medication for this condition? Yes No

If yes, what medications? _____ Epi-Pen? Yes No

Has the student been treated in an emergency room or hospital for this condition within the last year? Yes No

What are the functional limitation(s) caused by this condition and/or its treatment? _____

What environmental factors exacerbate this condition? _____

What environmental factors remediate the effects of this condition? _____

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

Anticipated Duration of Accommodation: _____

Physician/Health Care Provider Signature: _____

I, _____, authorize the above health-care provider to release to Student Disability Services the medical information requested on this form for the purpose of determining appropriate accommodation for my permanent or temporary disability while a student at Cornell University.

Signature of patient: _____ Date: _____

If signed by person other than patient, state relationship and authority to do so.

Relationship: _____ Legal Authority: _____