University of Sioux Falls
Request for Medical Exemption to On Campus Housing Requirement Supplemental Medical Need Verification Form

Please understand that for a variety of reasons, not all requests can be honored with the proper documentation. Therefore, only students with significant and debilitating conditions will be given priority. The student must submit this form no more than 60 days nor fewer than 30 days from the date of the start of the semester during which the exemption will first occur.

Please have your physician complete their part of this form and return it to the address listed at the end of this document. A prescription form or brief memo does not include sufficient information for our review process and will be returned.

In order to evaluate a student's needs for exemption to housing, the University of Sioux Falls requires specific diagnostic information from a licensed health care provider or clinical professional. This physician must be familiar with the history and functional limitations of the student's physical or psychological condition(s). The student must complete page one of the form below. **To facilitate this process, the University student is required to complete and sign the Permission to Release Information.** This signature allows the physician to provide information to the University, and allows the appropriate and qualified University of Sioux Falls staff members, permission to discuss the student's condition or resulting determination with the physician completing this form. The provider must complete the pages, sign, and return the completed packet to:

Mail: Department of Student Life
University of Sioux Falls
1101 W 22nd St
Sioux Falls
SD 57105

Student's Name: _____

Student ID#: _____ Phone Number: _____

Address: _____
(Street Address/PO Box/Residence Hall and Room) (City)
(State/Zip)

I give Dr. _____ of the _____
Medical Clinic/Center permission to release to the University of Sioux Falls any and all relevant medical information needed for the medical release for which I am applying. I also authorize my physician to discuss my condition(s) with the appropriate and qualified University of Sioux Falls personnel on an as needed basis.

Student Signature: _____ Date: _____

Physician Completes the Following Section

The following section is to be completed by the Doctor/Health Care Provider. If the space provided is not adequate, please continue on the back of the page. Attach additional information as necessary. All items must be completed in full. Partial or illegible responses will result in it being returned to the student/physician for clarification.

The provider filling out this form <u>cannot</u> be a relative of the student. Please do not submit a prescription pad note in lieu of completing this form.

1. How long have you known this patient? _____
2. What **specific issues** pose an <u>imminent risk</u> making it **<u>medically necessary</u>** for this student to consider options other than living in an on campus residential environment that supports the student which may include living in the University Apartments? State the symptoms and actual condition/diagnosis and explain in <u>lay</u> terms the medical/psychological rationale for how the condition(s) might affect the student's living situation: _____

   _____

   _____

   _____

   _____

   a. How often have you seen this person in the past 6 months for this specific condition? _____
   b. How long has the patient had this condition? _____
   c. What is the severity? _____
   d. How long is this condition likely to persist? _____
      i. What treatment(s) have been applied? _____
         1. Proven to be successful? _____
         2. Needed improvement? _____

3. Have you seen this patient for any other related conditions pertinent to this request? If yes, how recently and what was the treatment? _____

   _____

   _____

   _____

4. List the medications, including Over the Counter, and non-medication treatment that the student is currently using to manage this condition. Include dosage, frequency and adverse side effects. _____

   _____

   _____

   _____

a. Do these prescribed medications cause any significant day-to-day functional limitations on the student? No Yes – Please describe: _____

_____

_____

_____

5. Has the student ever been hospitalized as a result of the condition? If so, when was the last hospitalization? _____

_____

_____

6. What factor(s) improve and/or exacerbate this condition? _____

_____

_____

7. How frequently is the student affected by this condition? Daily Weekly Monthly Seasonally

The University of Sioux Falls offers multiple housing options for students including air-conditioned and non-air-conditioned halls of residence.

All buildings are smoke-free.

Therefore, it has been determined that allergies, generally are NOT a legitimate reason to be excused from the residence halls or apartments. Such request will ONLY be considered if there are extenuating circumstances.

8. For **allergy patients:** Has the patient been skin tested by an allergy specialist? If so, what were the results (it is not mandatory for students to receive one)? _____

_____

_____

a. Please list any specific allergens (that would be present in a furnished residence hall room or apartment) that this patient would have an allergic reaction to: _____

_____

_____

9. For **asthma patients:** Has the patient ever required prednisone or any other medications to manage the disease? If so, when was the last time? _____

_____

10. If the student is not a new, first-year or new, transfer student, what and/or how has the Student's medical condition changed that requires this request?

11. The University of Sioux Falls aims to make reasonable accommodations for students with disabilities and health issues. What accommodations might the University and or Student make in order for this student to be able to live in University Apartments or Residence Halls? (Check all that apply)
    a. Apt./ Room on first floor
    b. Wheelchair accessibility
    c. HEPA Air Filter Machine
    d. Humidifier
    e. Orthopedic mattress
    f. Air-conditioned room
    g. Close to restrooms (in residence halls)
    h. Other (Please explain):

12. What specific medication or equipment is required which would affect placement or room designation?

13. If off campus accommodations are stipulated, what recommendations are you making that will help accommodate this medical condition?

14. How will off campus accommodations be more beneficial then campus rooms or apartments that might have same or similar provisions?

Medical Professional: I understand that medical releases are based on significant (**NOT JUST IMPORTANT, BUT EXTREME IN NATURE)** or unforeseen medical conditions. The information I have submitted is accurate and should be taken into consideration when reviewing this student's record. I further understand that this information may be presented to the University of Sioux Falls Health and Counseling Services or referral physicians at the Avera Student Assistant Program or a certified mental health provider.

Doctor/Health Care Provider Signature:_____ Date: _____

Please print your name: _____

Phone: _____

Clinic/Hospital:_____

_____