Cleveland State University
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OFFICE OF DISABILITY SERVICES

Student Name:_____ CSU ID: _____ DOB: _____

I am requesting disability support services through the Office of Disability Services (ODS) at Cleveland State University. The department requires current and comprehensive documentation of my disability/medical condition as one of the criteria used to evaluate my eligibility for disability related accommodations and services. Please respond to the following questions as soon as possible. Once complete, you can return the document to me directly or submit it to ODS via email or fax. I authorize the Office of Disability Services to contact you if clarification is required.

Student signature: _____ Date: _____

Health Care Provider Name (print):_____

Title: _____

Phone: _____ EXT:_____ Fax: _____

Organization: _____

Mail address: _____

Note to Providers:

The information that you provide will **NOT** become part of the student's educational record(s), but it will be kept in the student's file at ODS, where it will be held strictly confidential.

Mailing Address: 2121 Euclid Ave, RW 210 • Cleveland, Ohio 44115-2214
Campus Location: Rhodes West 210• 2124 Chester Ave • Cleveland, Ohio
Telephone: (216) 687-2015 • Fax (216) 687-2343

The following information must be completed by the health care professional listed on the previous page.

Physician's name (print): _____ Date: _____

Student's name: _____

Date of last visit: _____

1. Diagnoses:

   _____

2. Date of diagnoses: _____

3. For environmental allergies, please list specific allergens:

   _____

4. Please indicate severity of environmental allergies for this student:

   - ◯ a. Mild
   - ◯ b. Moderate
   - ◯ c. Severe

5. Recommendations to the student for allergy management:

   _____

6. For Asthma, it is:

   - ◯ a. Mild intermittent
   - ◯ b. Mild persistent
   - ◯ c. Moderate persistent
   - ◯ d. Severe persistent

7. Please describe what specifically induces asthma attacks for this student:

_____

8. Recommendations to the student for asthma management:

_____

9. For food allergies, please list specific allergens:

_____

10. The following exposures will trigger a food allergy reaction for the student:

- ☐ a. Airborne particles
- ☐ b. Skin contact
- ☐ c. Ingestion
- ☐ d. Cross-contact
- ☐ e. Other (please describe below):

_____

11. The food allergies trigger the following reactions:

- ☐ a. Anaphylaxis
- ☐ b. Angioedema
- ☐ c. Rash
- ☐ d. Gastrointestinal symptoms
- ☐ e. Other (please explain):

_____

12. Procedures/assessments used to diagnose (please attach copies of assessment results used in making/ confirming diagnosis):

- [ ] a. Spirometry
- [ ] b. Allergy Testing
- [ ] c. Evaluation by allergy/asthma specialist
- [ ] d. Other (please explain):

13. Check the following that apply to this student:

- [ ] a. Was treated in the emergency room for this condition within the last year
- [ ] b. Has received in-patient treatment for this condition within the last year
- [ ] c. Prescribed allergy shots
- [ ] d. Prescribed short acting rescue inhaler
- [ ] e. Uses an epinephrine pen (i.e. Epi-pen)
- [ ] f. Recommended to use oral maintenance medications (including antihistamines, leukotriene inhibitors)
- [ ] g. Prescribed inhaled maintenance medications (including steroids, combined beta agonists)

14. Describe how the above condition(s) substantially limits a major life activity, and the condition(s) impact(s) on the student's daily life experience in the post-secondary setting (academics, communal living/dining, recreation):

15. Recommendations for health care and symptom management for the above condition while on campus:

This information is current and accurate to the best of my knowledge based on my recent evaluation of this patient or my review of records of a recent evaluation by a qualified health care provider.

Signature of Health Care Provider: _____

Printed Name: _____

License #: _____ Date: _____

Thank you for your assistance. You may return your report to the Office of Disability Services via email at **ODS@csuohio.edu** or by fax at **(216) 687-2343**.

Please call **(216) 687-2015** if you require additional information. Please attach any additional reports or relevant information (audiology reports, neuropsychological evaluations, etc). All information on this form will remain confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).