



RESIDENTIAL LIFE

GUSTAVUS ADOLPHUS COLLEGE

Documentation for Housing Accommodation Request

(To be completed by healthcare professional NOT related to the student- completed form **MUST** accompany any letters)

Student name: _____ Date of Birth: _____

Health Care Provider's Name: _____

Health Care Provider's credentials: _____

License or Certification Number: _____

Please note: Gustavus ensures equity for all students including equal access for students with disabilities. As a four-year residential college, learning to live in a community and share space with others is an integral part of students' educational experience. **A standard housing assignment is a two-person sleeping room where bathroom facilities are located on the same floor, but not in the room, and with access to a communal kitchen.** There are numerous campus locations that provide quiet spaces for studying.

Accommodation adjustments are made to facilitate equal access, **they are not intended to ensure a preferred or desired environment.** To establish a medical need for housing accommodation, unless the disability and the disability-related need for the accommodation is obvious and apparent, documentation of the disability is required.

The student named above has applied to stay or is staying in a residential facility on College campus. When it is not obvious that an individual is disabled or requires a requested accommodation/modification, the College needs to verify the same. We would appreciate your cooperation in answering the questions on this form and returning it as directed at the end of the form. The student has consented to the release of information, as noted on the separately attached Consent for the Release of Private Information signed by the student.

The student has requested the following accommodation/modification:

MAKE YOUR LIFE COUNT

Department of Residential Life
DIRECT 507-933-7529 | FAX 507-933-6197 | reslife@gustavus.edu
800 West College Avenue | St. Peter, Minnesota 56082-1498 | gustavus.edu/reslife



Please answer the following questions (please attach additional pages if space is required):

Definition of “Disabled”

Under federal law, an individual is disabled if he/she has a physical or mental impairment that substantially limits one or more major life activities; has a record of such an impairment; or is regarded as having such an impairment.

The term physical or mental impairment includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, autism, epilepsy, muscular dystrophy, multiple sclerosis, cancer, hearing disease, diabetes, Human Immunodeficiency Virus infection, intellectual or developmental disabilities, emotional illness, drug addiction, and alcoholism. This definition does not include any individual who is a drug addict and is currently using illegal drugs or an alcoholic who poses a direct threat to property or safety because of alcohol use.

The term major life activities means those activities that are of central importance to daily life, such as seeing, hearing, walking, breathing, performing manual tasks, caring for one’s self, learning and speaking.

Information Requested

- 1. Is the individual disabled as defined above? Yes No
 - a. Is the individual currently under your care? Yes No
- 2. Does the student require medical/therapeutic equipment? Yes No

If yes, please explain:

- 3. Would you or someone from your practice/organization be willing to discuss this matter with us if additional information or clarification is necessary? Yes No
- 4. Name and phone number of contact person:

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5. Description of student's functional limitations or behavioral manifestations in a college residence hall setting:

6. Describe any relevant side effects of prescription medications?

7. Given the standard housing assignment described on p.1, please describe and provide rationale for any modifications you are recommending to accommodate the students' disability. Please also explain how the modifications you recommend would assuage the functional limitations of the student's underlying condition.

8. If you are recommending a single room, please indicate whether and how there are any risks associated with isolation:

9. **(Dietary Accommodation ONLY)** Using as much space as needed, please describe the type, severity, and frequency of symptoms currently experienced by the student, and how the disability interferes with eating or dining in college facilities.

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- Life threatening/anaphylaxis (Student carries an epi-pen)
 - Due to airborne contact
 - Due to cross-contamination
 - Due to ingesting food, only
 - Other (please specify)

- High sensitivity, no anaphylaxis
 - Due to airborne contact
 - Due to cross-contamination
 - Due to ingesting food, only
 - Other (please specify)

10. **(Dietary Accommodation ONLY)** Describe the requested meal plan accommodation. Please explain how the requested accommodation is necessary to allow equal access to the College’s meal plan and facility.

In addition, mark all that apply.

- Gluten-free menu options
- Dairy and lactose-free options
- Vegetarian menu options
- Vegan menu options
- Access to Kosher menu options
- Specialized diets for gastrointestinal diseases (e.g. Chron’s, Celiacs, Colitis, IBS, etc.)
- Menu-planning consultation with Dining Services Dietician
- Other (please describe any modification(s) you believe are necessary; specify other food allergies, sensitivities and/or conditions)
- Exemption from meal plan

11. **(Dietary Accommodation ONLY)** If applicable and not already provided, please provide a list of foods that must be avoided(categories) and/or foods that are acceptable (categories).

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12. (To be completed for ALL Accommodation Requests!) What are the possible alternatives if meeting your primary recommendation is not possible?

Documentation will be kept in a confidential file available only to the members of the housing accommodation committee, whose recommendations are based on whether the medical documentation meets the above guidelines. The committee may seek additional information or clarification from the provider as needed.

Signature of Health Care Provider: _____ Date: _____

Please include a business card or official letterhead with documentation

Submit completed form to:

Director of Residential Life
Gustavus Adolphus College
800 West College Ave
St. Peter, MN 56082

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