OBERLIN
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Office for Disability & Access

# Severe Allergy Documentation Form

**STUDENT NAME**: _____

This form MUST be completed in its entirety by the student's treating physician for allergies. The student or a relative of the student may **NOT** complete any of the information on this form. To assist Oberlin's Office for Disability & Access (ODA), Residence Life (ResLife), and/or Dining Services in determining reasonable and appropriate disability accommodations, please complete the form below by:

**July 1** for First-year students and New Transfers

**March 12** for Continuing and Returning Students

***Important Disclaimer:*** *The Clarity dining location is a good choice for students with allergies or dietary restrictions. There are no* ***milk, soy, eggs, peanuts, tree nuts, shellfish, sesame,*** *or* ***wheat*** *ingredients used to prepare items at Clarity. Clarity prepares allergen-free entrees available in both meat and plant-forward options, absent of the eight common food allergens as listed above. Furthermore, most of the residence halls have community kitchens for students to use at any time.*

**Upon completion, submit the form by email (ODA@oberlin.edu) or fax (440-775-5589).**

## Certifying Licensed Medical or Mental Health Professional

**By signing below, you are verifying that you were solely responsible for completing this form, the information reflects your responses to the questions, you are treating this student, and are not a relative of the student.**

| | |
|---|---|
| Name: | Title: |
| Area(s) of Specialization: | |
| Phone Number: | Fax Number: |
| State of Licensure/Certification: | License/Certification Number: |
| Provider Signature: | Date: |

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**Table A:** Please complete the information below for **each specific allergy** (please also answer the questions on the following page that reference the allergen listed in this table)

| **TABLE A: PLEASE COMPLETE THIS TABLE FOR EACH SPECIFIC ALLERGY** | | | |
|---|---|---|---|
| **Allergen & Diagnosis Information** | **The following exposure triggers an allergic reaction** | **The allergy causes the following reaction(s)** | **Procedures/assessments used to diagnose the student's condition** |
| **Allergen:**<br><br>**Severity:**<br>☐ Mild<br>☐ Moderate<br>☐ Severe<br>☐ Don't Know<br><br>**Date of Initial Diagnosis:**<br><br>**Date of last office visit for this allergen:**<br><br>**Date of last reaction:** | ☐ Airborne particles<br>☐ Skin contact<br>☐ Ingestion<br>☐ Cross-contamination<br>☐ *Other:* *(please describe)* | ☐ Shortness of breath, wheezing, repetitive coughing<br>☐ Weak and rapid pulse<br>☐ Hives<br>☐ Constricted airways<br>☐ Swelling of tongue and/or lips<br>☐ Nausea, vomiting, diarrhea<br>☐ Dizziness or fainting<br>☐ *Other:* *(please describe)* | ☐ Spirometry<br>☐ Allergy Testing<br>☐ Evaluation by Allergy / Asthma Specialist<br>☐ Other: *(please describe)* |

**How many times has the student had a reaction to this specific allergen?** Please explain. *(Never, once, more than once, etc.)*

**Are the allergy reactions staying the same, getting worse, or getting better?**

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***REGARDING THE ALLERGEN LISTED ABOVE (IN TABLE A):***

**What accommodation(s) do you recommend?** *These must be clearly linked to the Student's diagnosis and functional limitations*

**In what way(s) will the proposed housing/dining accommodation(s) help to alleviate symptoms of the Student's allergy?**

135 W Lorain St | Wilder Hall, Room 112 | Oberlin, OH 44074-1091 USA
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**How many times has the student had a reaction to this specific allergen?** Please explain. *(Never, once, more than once, etc.)*

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**TABLE B: PLEASE COMPLETE THIS TABLE TO DESCRIBE THE OVERALL IMPACTS ON THE STUDENT'S DAILY LIFE**

**Do the Student's allergies substantially impact a major life activity (e.g., seeing, hearing, eating, sleeping, walking, self-care, etc.) or bodily function (e.g., digestion, respiratory, circulatory, etc.)?**

☐ Yes ☐ No

If no, please explain:

**If the Student's allergies substantially impacts a major life activity, please provide more details below.**

| Check the area of functioning/major life activities impacted | Please complete the information for each specific allergen that was listed above | How is this area of functioning/major life activity impacted by the allergy? |
|---|---|---|
| ☐ **Digestive** | **Allergen(s) causing limitations or impact:** | |
| ☐ **Bowel** | **Allergen(s) causing limitations or impact:** | |
| ☐ **Bladder** | **Allergen(s) causing limitations or impact:** | |

| | | |
|---|---|---|
| ☐ **Immune System** | **Allergen(s) causing limitations or impact:** | |
| ☐ **Respiratory** | **Allergen(s) causing limitations or impact:** | |
| ☐ **Neurological Systems** | **Allergen(s) causing limitations or impact:** | |
| ☐ **Eating** | **Allergen(s) causing limitations or impact:** | |

| | | |
|---|---|---|
| ☐ **Other** | **Allergen(s) causing limitations or impact:** | |
| ☐ **Other** | **Allergen(s) causing limitations or impact:** | |
| ☐ **Other** | **Allergen(s) causing limitations or impact:** | |

**Additional Information:**
*Check all the following that apply to this Student*

☐ Was treated in the emergency room for this condition within the past year.
**If yes, which allergen(s)?**

☐ Has received in-patient treatment for this condition within the past year.
**If yes, which allergen(s)?**

☐ Has asthma

☐ Received allergy shots within the past year

☐ Uses a short acting rescue inhaler

☐ Uses an epinephrine pen (i.e. epi-pen)

☐ Recommended to use oral maintenance medications (e.g. antihistamines, leukotriene inhibitors)

☐ Prescribed inhaled maintenance medications (e.g. steroids, combined beta agonists)

☐ Prescribed other medications for allergies
**If yes, please list:**

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**Do you have any other recommendations for the health-care management of this condition?**

**Upon completion, submit the form by email (ODA@oberlin.edu) or fax (440-775-5589).**

Please do not hesitate to contact our office (phone: **440-775-5588**) with any questions or concerns.

Your assistance with our evaluation of the student's request is greatly appreciated.

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