COLUMBIA HEALTH
Disability Services

Wien Hall, Suite 108A
411 W. 116th Street, Mail Code 3714
New York, NY 10027

Phone (212) 854-2388 (Voice/TTY)
Fax (212) 854-3448 disability@columbia.edu
www.health.columbia.edu/ods

Verification of Disability Form for Asthma and Allergy Conditions

Purpose: The student named below has indicated that s/he has asthma or allergies that rise to the level of disability and will require reasonable accommodations to participate in a program or activity (including housing) at Columbia University. The information you provide will be used to determine the nature and severity of the student's condition and the appropriateness of requested accommodations or services. **Please take the time to complete this form in its entirety.** Contact Disability Services (DS) at (212) 854-2388 with any questions. All information provided to us is kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA). A signed consent for release of information should be completed by the student prior to the release of this form. Thank you for your assistance.

Student Name: _____

Diagnosis: _____

Date of Diagnosis: _____

Date of last visit for this condition: _____

Procedures/assessments used to diagnose this student's condition (Please attach copy of test results; eg: allergy testing, pulmonary function testing, etc.):

_____
_____

_____

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

Has the student been treated in an emergency room or hospital for this condition within the last year?

☐ Yes ☐ No

Total number of hospitalizations related to this condition: _____

Date of last hospitalization: _____

What environmental factors exacerbate this condition? _____

_____
_____
_____
_____

_____

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

If yes, please specify medications, dosage and frequency:

Medication	Dosage	Frequency

Does the student use a prescribed inhaler regularly? ☐ Yes ☐ No

What are the functional limitations caused by this condition and/or its treatment? _____

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

_____

Anticipated duration of need for accommodation: _____

Name of Medical Professional: _____

License #: _____

Please indicate State: _____

Address: _____

Telephone: _____

Signature (verifying that you are not related to the student by blood or marriage):

_____

Date: _____