

OBERLIN

COLLEGE & CONSERVATORY

Office of Student Accessibility Services

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 of Student Accessibility Services (OSAS), Housing and Residential Education (HRE), and/or Dining Services in determining reasonable and appropriate disability accommodations, please complete the form below by:

June 1 for First-year students and New Transfers

March 1 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 (OSAS@oberlin.edu) or fax ([440-775-5589](tel: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:

OBERLIN

COLLEGE & CONSERVATORY

Office of Student Accessibility Services

Table A: Please complete the information below for **each specific allergy**

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		<input type="checkbox"/> Airborne particles	<input type="checkbox"/> Shortness of breath, wheezing, repetitive coughing	<input type="checkbox"/> Spirometry
Date of Initial Diagnosis		<input type="checkbox"/> Skin contact	<input type="checkbox"/> Weak and rapid pulse	<input type="checkbox"/> Allergy Testing
		<input type="checkbox"/> Ingestion	<input type="checkbox"/> Hives	<input type="checkbox"/> Evaluation by Allergy/Asthma Specialist
Date of last office visit for this allergen		<input type="checkbox"/> Cross-contamination	<input type="checkbox"/> Constricted airways	<input type="checkbox"/> Other:
Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Don't Know		<input type="checkbox"/> Other:	<input type="checkbox"/> Swelling of tongue and/or lips	
			<input type="checkbox"/> Nausea, vomiting, diarrhea	
			<input type="checkbox"/> Dizziness or fainting	
			<input type="checkbox"/> Other:	

REGARDING THE ALLERGEN LISTED ABOVE:

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

When was the last reaction?

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

OBERLIN

COLLEGE & CONSERVATORY

Office of Student Accessibility Services

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		<input type="checkbox"/> Airborne particles	<input type="checkbox"/> Shortness of breath, wheezing, repetitive coughing	<input type="checkbox"/> Spirometry
Date of Initial Diagnosis		<input type="checkbox"/> Skin contact	<input type="checkbox"/> Weak and rapid pulse	<input type="checkbox"/> Allergy Testing
		<input type="checkbox"/> Ingestion	<input type="checkbox"/> Hives	<input type="checkbox"/> Evaluation by Allergy/Asthma Specialist
Date of last office visit for this allergen		<input type="checkbox"/> Cross-contamination	<input type="checkbox"/> Constricted airways	<input type="checkbox"/> Other:
Severity:		<input type="checkbox"/> <i>Other:</i>	<input type="checkbox"/> Swelling of tongue and/or lips	
<input type="checkbox"/> Mild			<input type="checkbox"/> Nausea, vomiting, diarrhea	
<input type="checkbox"/> Moderate			<input type="checkbox"/> Dizziness or fainting	
<input type="checkbox"/> Severe			<input type="checkbox"/> <i>Other:</i>	
<input type="checkbox"/> Don't Know				

REGARDING THE ALLERGEN LISTED ABOVE:

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

When was the last reaction?

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

OBERLIN

COLLEGE & CONSERVATORY

Office of Student Accessibility Services

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		<input type="checkbox"/> Airborne particles	<input type="checkbox"/> Shortness of breath, wheezing, repetitive coughing	<input type="checkbox"/> Spirometry
Date of Initial Diagnosis		<input type="checkbox"/> Skin contact	<input type="checkbox"/> Weak and rapid pulse	<input type="checkbox"/> Allergy Testing
		<input type="checkbox"/> Ingestion	<input type="checkbox"/> Hives	<input type="checkbox"/> Evaluation by Allergy/Asthma Specialist
Date of last office visit for this allergen		<input type="checkbox"/> Cross-contamination	<input type="checkbox"/> Constricted airways	<input type="checkbox"/> Other:
Severity:		<input type="checkbox"/> <i>Other:</i>	<input type="checkbox"/> Swelling of tongue and/or lips	
<input type="checkbox"/> Mild			<input type="checkbox"/> Nausea, vomiting, diarrhea	
<input type="checkbox"/> Moderate			<input type="checkbox"/> Dizziness or fainting	
<input type="checkbox"/> Severe			<input type="checkbox"/> <i>Other:</i>	
<input type="checkbox"/> Don't Know				

REGARDING THE ALLERGEN LISTED ABOVE:

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

When was the last reaction?

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

OBERLIN

COLLEGE & CONSERVATORY

Office of Student Accessibility Services

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		<input type="checkbox"/> Airborne particles	<input type="checkbox"/> Shortness of breath, wheezing, repetitive coughing	<input type="checkbox"/> Spirometry
Date of Initial Diagnosis		<input type="checkbox"/> Skin contact	<input type="checkbox"/> Weak and rapid pulse	<input type="checkbox"/> Allergy Testing
		<input type="checkbox"/> Ingestion	<input type="checkbox"/> Hives	<input type="checkbox"/> Evaluation by Allergy/Asthma Specialist
Date of last office visit for this allergen		<input type="checkbox"/> Cross-contamination	<input type="checkbox"/> Constricted airways	<input type="checkbox"/> Other:
Severity:		<input type="checkbox"/> <i>Other:</i>	<input type="checkbox"/> Swelling of tongue and/or lips	
<input type="checkbox"/> Mild			<input type="checkbox"/> Nausea, vomiting, diarrhea	
<input type="checkbox"/> Moderate			<input type="checkbox"/> Dizziness or fainting	
<input type="checkbox"/> Severe			<input type="checkbox"/> <i>Other:</i>	
<input type="checkbox"/> Don't Know				

REGARDING THE ALLERGEN LISTED ABOVE:

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

When was the last reaction?

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

OBERLIN

COLLEGE & CONSERVATORY

Office of Student Accessibility Services

Does the Student's allergy 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 allergy 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?
<input type="checkbox"/> Digestive	Allergen(s) causing limitations or impact:	
<input type="checkbox"/> Bowel	Allergen(s) causing limitations or impact:	
<input type="checkbox"/> Bladder	Allergen(s) causing limitations or impact:	

OBERLIN

COLLEGE & CONSERVATORY

Office of Student Accessibility Services

<input type="checkbox"/> Immune System	Allergen(s) causing limitations or impact:	
<input type="checkbox"/> Respiratory	Allergen(s) causing limitations or impact:	
<input type="checkbox"/> Neurological Systems	Allergen(s) causing limitations or impact:	
<input type="checkbox"/> Eating	Allergen(s) causing limitations or impact:	

OBERLIN

COLLEGE & CONSERVATORY

Office of Student Accessibility Services

<input type="checkbox"/> Other	Allergen(s) causing limitations or impact:	
<input type="checkbox"/> Other	Allergen(s) causing limitations or impact:	
<input type="checkbox"/> 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:

OBERLIN

COLLEGE & CONSERVATORY

Office of Student Accessibility Services

PLEASE COMPLETE THE INFORMATION FOR EACH SPECIFIC ALLERGEN

	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?
Allergen(s):		

OBERLIN

COLLEGE & CONSERVATORY

Office of Student Accessibility Services

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

Upon completion, submit the form by email (OSAS@oberlin.edu) or fax ([440-775-5589](tel:440-775-5589)).

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

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