OBERLIN
COLLEGE & CONSERVATORY

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: **Severity:** ☐ Mild ☐ Moderate ☐ Severe ☐ Don't Know **Date of Initial Diagnosis:** **Date of last office visit for this allergen:** **Date of last reaction:**	☐ Airborne particles ☐ Skin contact ☐ Ingestion ☐ Cross-contamination ☐ *Other: (please describe)*	☐ Shortness of breath, wheezing, repetitive coughing ☐ Weak and rapid pulse ☐ Hives ☐ Constricted airways ☐ Swelling of tongue and/or lips ☐ Nausea, vomiting, diarrhea ☐ Dizziness or fainting ☐ *Other: (please describe)*	☐ Spirometry ☐ Allergy Testing ☐ Evaluation by Allergy / Asthma Specialist ☐ 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?

148 W College St | Mudd Center, Room 205 | Oberlin, OH 44074-1091 USA
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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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