Albion College
Office of Community Living

Housing Accommodations Form 2024-2025

Medical Professional Supporting Section

Housing Accommodations are provided on a case-by-case basis in accordance with the Americans with Disabilities Act, as amended in 2008. To qualify, the student must have a current condition that substantially limits a major life activity, and the accommodation request must be necessary and reasonable. A diagnosis, in and of itself, does not automatically qualify for accommodations.

If you are completing this form, the student should have shared a copy of their responses and a signed release of information.

Please print, complete, sign, and return to fax or scan to the email address listed below along with any attached supporting documents.

Information is released to the Director of Community Living and Student Conduct, and the Office of Accessibility Services.

This section is to be completed by the student's healthcare provider.

Student Name: _____

History of presenting problem and current medical condition/diagnosis:

Expected duration of condition (circle one):

Temporary
Permanent
Stable
Progressive

Describe the symptoms related to the medical condition that cause significant impairment to a major life activity (i.e. walking, breathing, sleeping, seeing, hearing, learning, socializing).

Please relate it to accommodations requested.

List the current medication(s) the student has been prescribed and any adverse side effects. Are

there any other factors that contribute to this student's need for the requested accommodation?

Accommodations Requested.

Please indicate below your recommendations regarding housing accommodations for this student. Please note that the accommodations marked with an asterisk (*) are extremely limited and will only be considered for students meeting ADA criteria.

Air conditioned housing
Close to bathroom
Exemption to meal plan requirement
Exemption to residency requirement
Room assignment without stairs
No extended housing (no triple/quad rooms)
Semi-private bathroom/private bathroom*
Service animal*
Single room
Strobe light emergency alerts*
Wheelchair accessible*
Other: _____

Please attach any additional documentation/pages (e.g. notes, medical information, test results, etc.)

Provider Information

Name (print or type): _____

Signature of professional: _____ Date: _____

License No.: _____ State: _____ Phone: _____

Address - Street:_____

City:_____ State: _____ Zip: _____

Email Address: _____