



RICE UNIVERSITY

Student Disability Resource Center

Medical Documentation Form: Environmental Allergies or Asthma

Students with environmental allergies, and/or asthma should have their health care provider

- 1) Complete the documentation form
- 2) Provide a copy of recent allergy/asthma testing results

Student's treating physician completes this section. All items are required. Please print legibly.

Today's Date: ___/___/_____

Physician's Name (please print): _____

Student's Name: _____

Diagnosis and ICD 10 diagnostic codes: _____

Date of diagnosis: ___/___/_____

Date of last visit for condition(s): ___/___/_____

For Environmental allergies, please list the specific allergens: _____

Please indicate the severity of environmental allergies for this student:

Mild _____ Moderate _____ Severe _____

Recommendations to the student for allergy management: _____

For Asthma, please indicate the severity:

___ Mild intermittent ___ Mild persistent ___ Moderate persistent ___ Severe persistent

What specifically induces asthma attacks for this student: _____

Recommendations to the student for asthma management: _____



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List the procedures, lab tests, evaluation instruments, and any other measures used by an allergy/asthma specialist in the assessment process used in making/ confirming diagnosis: _____

(PLEASE ATTACH COPIES OF ASSESSMENT RESULTS)

Check the following that apply to this student:

- Was treated in the emergency room for this condition within the last year
- Has received in-patient treatment for this condition within the last year
- Prescribed allergy shots
- Prescribed short acting rescue inhaler
- Over-the-counter medications (list): _____
- Prescription medications (list): _____
- Recommended to use oral maintenance medications (including antihistamines, leukotriene inhibitors)
- Prescribed inhaled maintenance medications (including steroids, combined beta agonists)

Describe how the above condition(s) substantially limits a major life activity that the average person in the general population can perform with little or no difficulty, and the condition(s) impact(s) on the student's daily life experience in the post-secondary setting (academics, communal living/dining, recreation):

Recommendations for health care and symptom management for the above condition while on campus:



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Physician Signature: _____

Physician's Name: _____

Address: _____

License/Cert.: _____ State: _____

Speciality: _____

Phone: ()-_____-_____
Fax: ()-_____-_____

Affix business card or apply business
stamp within this box: