



Disability Resource Center
Severe Allergy Documentation Form

Student's 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 UNC's Disability Resource Center (DRC), 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

This information can be submitted by email (drc@unco.edu) or fax (970-351-4166). Please contact our office with any questions or concerns (970-351-2289). Your assistance with our evaluation of the student's request is greatly appreciated.

Important Disclaimer: *The DASH food station is a good choice for students with allergies or dietary restrictions. There are no **milk, soy, eggs, peanuts, tree nuts, shellfish, or wheat ingredients** used to prepare items on The DASH menus. Items at The DASH are prepared in a facility and with equipment that could come into contact with these items. Our staff is trained in preventing cross-contact of these items during preparation and service of DASH menu items. Furthermore, most of the residence halls have community kitchens for students to use at any time.*

Certifying Licensed Medical or Mental Health Professional

By signing below, you are verifying that you are currently treating this student and that you completed this form in its entirety and it reflects your responses to the questions.

Name: _____ **Title:** _____

Area(s) of Specialization: _____

State of licensure/Certification: _____ **License/Certification Number:** _____

Phone Number: _____ **Fax:** _____

Provider Signature: _____ **Date:** _____

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

	The following exposure triggers an allergic reaction:	The allergy causes the following reaction:	Procedures/assessments used to diagnose student's condition:
Allergen: _____ Date of initial diagnosis: _____	<input type="checkbox"/> airborne particles <input type="checkbox"/> skin contact <input type="checkbox"/> ingestion <input type="checkbox"/> cross-contamination <input type="checkbox"/> other:	<input type="checkbox"/> Shortness of breath, wheezing, repetitive coughing <input type="checkbox"/> Weak and rapid pulse <input type="checkbox"/> Hives <input type="checkbox"/> Constricted airways	<input type="checkbox"/> spirometry <input type="checkbox"/> allergy testing <input type="checkbox"/> evaluation by allergy/asthma specialist <input type="checkbox"/> other:

Date of last office visit for this allergen: <hr/>		<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:	
Allergen: <hr/> Date of initial diagnosis: <hr/> Date of last office visit for this allergen: <hr/>	<input type="checkbox"/> airborne particles <input type="checkbox"/> skin contact <input type="checkbox"/> ingestion <input type="checkbox"/> cross-contamination <input type="checkbox"/> other:	<input type="checkbox"/> Shortness of breath, wheezing, repetitive coughing <input type="checkbox"/> Weak and rapid pulse <input type="checkbox"/> Hives <input type="checkbox"/> Constricted airways <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:	<input type="checkbox"/> spirometry <input type="checkbox"/> allergy testing <input type="checkbox"/> evaluation by allergy/asthma specialist <input type="checkbox"/> other:
Allergen: <hr/> Date of initial diagnosis: <hr/> Date of last office visit for this allergen: <hr/>	<input type="checkbox"/> airborne particles <input type="checkbox"/> skin contact <input type="checkbox"/> ingestion <input type="checkbox"/> cross-contamination <input type="checkbox"/> other:	<input type="checkbox"/> Shortness of breath, wheezing, repetitive coughing <input type="checkbox"/> Weak and rapid pulse <input type="checkbox"/> Hives <input type="checkbox"/> Constricted airways <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:	<input type="checkbox"/> spirometry <input type="checkbox"/> allergy testing <input type="checkbox"/> evaluation by allergy/asthma specialist <input type="checkbox"/> other:
Allergen: <hr/> Date of initial diagnosis: <hr/> Date of last office visit for this allergen: <hr/>	<input type="checkbox"/> airborne particles <input type="checkbox"/> skin contact <input type="checkbox"/> ingestion <input type="checkbox"/> cross-contamination <input type="checkbox"/> other:	<input type="checkbox"/> Shortness of breath, wheezing, repetitive coughing <input type="checkbox"/> Weak and rapid pulse <input type="checkbox"/> Hives <input type="checkbox"/> Constricted airways <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:	<input type="checkbox"/> spirometry <input type="checkbox"/> allergy testing <input type="checkbox"/> evaluation by allergy/asthma specialist <input type="checkbox"/> other:
Allergen: <hr/>	<input type="checkbox"/> airborne particles <input type="checkbox"/> skin contact <input type="checkbox"/> ingestion <input type="checkbox"/> cross-contamination <input type="checkbox"/> other:	<input type="checkbox"/> Shortness of breath, wheezing, repetitive coughing <input type="checkbox"/> Weak and rapid pulse <input type="checkbox"/> Hives	<input type="checkbox"/> spirometry <input type="checkbox"/> allergy testing <input type="checkbox"/> evaluation by allergy/asthma specialist <input type="checkbox"/> other:

Date of initial diagnosis: <hr/> Date of last office visit for this allergen: <hr/>		<input type="checkbox"/> Constricted airways <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:	
Allergen: <hr/> Date of initial diagnosis: <hr/> Date of last office visit for this allergen: <hr/>	<input type="checkbox"/> airborne particles <input type="checkbox"/> skin contact <input type="checkbox"/> ingestion <input type="checkbox"/> cross-contamination <input type="checkbox"/> other:	<input type="checkbox"/> Shortness of breath, wheezing, repetitive coughing <input type="checkbox"/> Weak and rapid pulse <input type="checkbox"/> Hives <input type="checkbox"/> Constricted airways <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:	<input type="checkbox"/> spirometry <input type="checkbox"/> allergy testing <input type="checkbox"/> evaluation by allergy/asthma specialist <input type="checkbox"/> other:

Please complete the information for each specific allergen that was listed in Table A.

Write-in each specific allergen below.	How many times has the student had a reaction? 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?	Please circle the severity of the allergy.
Allergen: _____				Mild Moderate Severe Do not know
Allergen: _____				Mild Moderate Severe Do not know
Allergen: _____				Mild Moderate Severe Do not know
Allergen: _____				Mild Moderate Severe Do not know
Allergen: _____				Mild Moderate Severe Do not know
Allergen: _____				Mild Moderate Severe

Limitations Caused by the Allergy:

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.)?

- No (please explain): _____

- Yes-If yes, please complete the information below.

Please complete the information for each specific allergen that was listed above.	Check the area of functioning/major life activities impacted:	How is this area of functioning/major life activity impacted by the allergy?
Allergen(s): _____ _____	<input type="checkbox"/> Digestive	
Allergen(s): _____ _____	<input type="checkbox"/> Bowel	
Allergen(s): _____ _____	<input type="checkbox"/> Bladder	
Allergen(s): _____ _____	<input type="checkbox"/> Immune system	
Allergen(s): _____ _____	<input type="checkbox"/> Respiratory	
Allergen(s): _____ _____	<input type="checkbox"/> Neurological systems	

Allergen(s): _____ _____	<input type="checkbox"/> Eating	
Allergen(s): _____ _____	<input type="checkbox"/> Other:	
Allergen(s): _____ _____	<input type="checkbox"/> Other:	
Allergen(s): _____ _____	<input type="checkbox"/> Other:	

Please complete the information for each specific allergen.

	What accommodation(s) do you recommend? Must be clearly linked to student's diagnosis and functional limitations.	In what ways will the proposed housing/dining accommodation(s) help to alleviate symptoms of the student's allergy?
Allergen(s): _____ _____		
Allergen(s): _____ _____		
Allergen(s): _____ _____		
Allergen(s): _____ _____		
Allergen(s): _____ _____		

Additional Information:

Check 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: _____

Recommendations for the health-care management of this condition: