UNIVERSITY OF
NORTHERN COLORADO

Disability Support Services

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

May 1 for First-year students and New Transfers
March 1 for Continuing and Returning Students

This information can be submitted by email (DisabilitySupport@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**: _____	□ airborne particles □ skin contact □ ingestion □ cross-contamination □other:	□ Shortness of breath, wheezing, repetitive coughing □ Weak and rapid pulse □ Hives □ Constricted airways	□ spirometry □ allergy testing □ evaluation by allergy/asthma specialist □other:

Date of last office visit for this allergen: _______________________		☐ Swelling of tongue and/or lips ☐ Nausea, vomiting, diarrhea ☐ Dizziness or fainting ☐other:	
Allergen: _______________________ **Date of initial diagnosis**: _______________________ **Date of last office visit for this allergen**: _______________________	☐ airborne particles ☐ skin contact ☐ ingestion ☐ cross-contamination ☐other:	☐ 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:	☐ spirometry ☐ allergy testing ☐ evaluation by allergy/asthma specialist ☐other:
Allergen: _______________________ **Date of initial diagnosis**: _______________________ **Date of last office visit for this allergen**: _______________________	☐ airborne particles ☐ skin contact ☐ ingestion ☐ cross-contamination ☐other:	☐ 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:	☐ spirometry ☐ allergy testing ☐ evaluation by allergy/asthma specialist ☐other:
Allergen: _______________________ **Date of initial diagnosis**: _______________________ **Date of last office visit for this allergen**: _______________________	☐ airborne particles ☐ skin contact ☐ ingestion ☐ cross-contamination ☐other:	☐ 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:	☐ spirometry ☐ allergy testing ☐ evaluation by allergy/asthma specialist ☐other:
Allergen: _______________________	☐ airborne particles ☐ skin contact ☐ ingestion ☐ cross-contamination ☐other:	☐ Shortness of breath, wheezing, repetitive coughing ☐ Weak and rapid pulse ☐ Hives	☐ spirometry ☐ allergy testing ☐ evaluation by allergy/asthma specialist ☐other:

Date of initial diagnosis: _____ **Date of last office visit for this allergen**: _____		□ Constricted airways □ Swelling of tongue and/or lips □ Nausea, vomiting, diarrhea □ Dizziness or fainting □other:	
Allergen: _____ **Date of initial diagnosis**: _____ **Date of last office visit for this allergen**: _____	□ airborne particles □ skin contact □ ingestion □ cross-contamination □other:	□ 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:	□ spirometry □ allergy testing □ evaluation by allergy/asthma specialist □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

				Do not know

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):_____ _____	□ Digestive	
Allergen(s):_____ _____	□ Bowel	
Allergen(s):_____ _____	□ Bladder	
Allergen(s):_____ _____	□ Immune system	
Allergen(s):_____ _____	□ Respiratory	
Allergen(s):_____ _____	□ Neurological systems	

Allergen(s):_____ _____	□ Eating	
Allergen(s):_____ _____	□ Other:	
Allergen(s):_____ _____	□ Other:	
Allergen(s):_____ _____	□ 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: