RELEASE OF INFORMATION
FOR VERIFICATION OF MEDICAL DOCUMENTATION OF AN ALLERGY DISABILITY

The student completes the following:

I, _____, herby authorize the release of the following information as well as any pertinent documentation to the Student Accessibility Services at Florida Atlantic University for the purpose of determining my eligibility for academic accommodations.

Student's Signature _____ Phone: _____

Student's Z# _____ Date of Birth: _____

☐ Please return paperwork to client/student.

☐ Please return the completed information to the campus checked below:

☐ Florida Atlantic University
Student Accessibility Services
777 Glades Road, SU 133
Boca Raton, FL 33431
tel: 561.297.3880 fax: 561.297.2184

☐ Florida Atlantic University
Student Accessibility Services
3200 College Avenue, LA 131
Davie, FL 33314
tel: 954.236.1222 fax: 954.236.1123

☐ Florida Atlantic University
Student Accessibility Services
5353 Parkside Drive, SR 111F
Jupiter, FL 33458
tel: 561.799.8585 fax: 561.799.8819

Florida Atlantic University
Student Accessibility Services
MEDICAL DOCUMENTATION OF AN ALLERGY DISABILITY

Student's Name: _____

1. Disability Diagnosis _____

_____

2. Date of diagnosis_____

3. Current symptoms and severity of this condition _____

_____

_____

4. List of allergens_____

_____

_____

5. Prescribed treatment or medications_____

_____

_____

_____

6. Epipen? YES☐ NO☐

7. Has the student been treated in an emergency room for this condition within the last year? YES☐ NO☐

8. Has the student received inpatient treatment for this condition within the last year?
YES☐ NO☐

9. Describe in detail how this condition substantially limits a major life activity.

_____

_____

_____

10. Does the student have dietary restrictions? YES☐ NO☐

If yes, explain _____

_____

_____

11. Recommended accommodation(s) – please be specific.

_____

_____

_____

_____

12. Why is this accommodation necessary for the condition? _____

_____

_____

_____

PHYSICIAN'S NAME (Printed) _____

PHYSICIAN'S SIGNATURE_____ DATE_____

CREDENTIALS_____ SPECIALTY_____

LICENSE/CERT. # _____ STATE_____

Please attach your business card.