REQUEST FOR MEDICAL EXEMPTION TO HOUSING PACKET

Please understand that for a variety of reasons, not all requests can be honored. Therefore, only students with significant and debilitating conditions will be given priority.

Please have your physician or mental health provider complete their part of this form and return it to the address below. A prescription form or brief memo does not include sufficient information for our review process.

**Submission Deadlines:**
- July 15th for the fall semester
- December 4th for spring semester

**Special Points:**
- Single rooms are very limited.
- Purchase of an air purifier and/or humidifier is the responsibility of the student (room to room air conditioning is available in three of the residence halls; hallway air conditioning is provided in the other two residence halls).
- Failure to submit required documentation by appropriate deadline will result in a room and meal plan assignment (until adequate documentation has been submitted for consideration).

If you have any questions, please call our office at (605) 256-5146. Your assistance with this process is greatly appreciated.

Sincerely,

The Department of Residence Life

Return the form to:
Dakota State University
Department of Residence Life
820 N Washington Avenue
Madison, SD 57042
FAX: (605) 256-5150
DAKOTA STATE UNIVERSITY
DEPARTMENT OF RESIDENCE LIFE
REQUEST FOR MEDICAL EXEMPTION TO HOUSING

In order to evaluate a student’s needs for special housing assignment requests, the University requires specific diagnostic information from a licensed health care provider or clinical professional. This physician or mental health provider must be familiar with the history and functional limitations of the student’s physical or psychological condition(s). The student must complete page one of the form below. To facilitate this process, the University student is required to fill out and sign the Permission to Release Information. This signature allows the physician or mental health provider to provide information to the University, and allows the appropriate and qualified Dakota State University staff members, permission to discuss the student’s condition or resulting determination with the physician or mental health provider filling out this form. The provider must fill out pages two and three, sign, and return the completed packet to:

Dakota State University    FAX: (605) 256-5150
Department of Residence Life
820 N Washington Avenue
Madison, SD 57042

Student Completes the Section Below (Please Print or Type):

Student Name: ________________________________________________________________________  
(Last)    (First)     (Middle Initial)  
Student ID#: _______________________    E-Mail: __________________________
Birth date: _________________________   Gender:

 Male   Female
Home Phone: _______________________   Cell Phone: _______________________
Reason for Requesting Medical Exemption: ____________________________________________
__________________________________________________________________________________
I am requesting consideration for:  (Check the appropriate box below.)

 Placement in an on-campus single occupancy room.
 Approval to live off campus.

PERMISSION TO RELEASE INFORMATION

I give my physician permission to provide information pertaining to my medical/psychological need for special housing. I also authorize my physician to discuss my condition(s) with the appropriate and qualified Dakota State University personnel on an as needed basis.

Student’s signature: ________________________________________________________________
Date: ______________________

Submission deadlines:  • July 15th for the fall semester  • December 4th for spring semester

Physician or Mental Health Provider Fills Out the Section Below
The provider filling out this form cannot be a relative of the student. Please do not submit a prescription pad note in lieu of filling out this form.

All items must be completed in full. If the space provided is not adequate, please continue on the back of the page. The physician may also attach a report providing additional related information.

STUDENT’S NAME: _________________________________________________________________________

1. How long have you known this patient? __________________________________________________

2. State the symptoms and actual condition/diagnosis and explain in lay terms the medical/psychological rationale for how the treatment might affect the student’s living situation: ______________________________________________________

   a. How long has the patient had this condition? ___________________________________________
   
   b. What is the severity of the condition? _________________________________________________
   
   c. In the last year, how many times have you treated this student for this condition? ____________

   d. How long is this condition likely to persist? _____________________________________________

3. Have you seen this patient for any other related conditions pertinent to this request? If yes, how recently and what was the treatment? ______________________________________________________

4. List all medications, including OTC, and non-medication treatment that the student is currently using to manage this condition. Include dosage, frequency, and adverse side effects.

   a. Do these prescribed medications cause any significant day-to-day functional limitations on the student? □ No □ Yes-please describe: _______________________________________________

5. Has the student ever been hospitalized as a result of the condition? If so, when was the last hospitalization? ________________________________________________________________________

6. What factor(s) improve and/or exacerbate this condition? __________________________________________

7. How frequently is the student affected by this condition?

   □ Daily □ Weekly □ Monthly □ Seasonally

Dakota State University offers multiple housing options for students. Three of our five residence halls have room to room air conditioning and the other two offer hallway air conditioning. All halls are smoke-free. All public areas are vacuumed every day and all lavatories are cleaned and disinfected daily. Annually air filters...
in student rooms are replaced and central ventilation filters are changed twice annually. All rooms in the system are equipped with operational windows.

**THEREFORE, IT HAS BEEN DETERMINED THAT ALLERGIES GENERALLY ARE NOT A LEGITIMATE REASON TO BE EXCUSED FROM THE RESIDENCE HALLS. SUCH REQUESTS WILL ONLY BE CONSIDERED IF THERE ARE EXTENUATING CIRCUMSTANCES.**

8. For allergy patients: Has the patient been skin tested by an allergy specialist? If so, what were the results (it is not mandatory for students to receive one)? ____________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

   a. Please list any specific allergens that would be present in an unfurnished residence hall room that this patient would have an allergic reaction to: ____________________________________________
____________________________________________________________________________________

9. For asthma patients: Has the patient ever required prednisone to manage the disease? If so, when was the last time? __________________________________________________________________________
____________________________________________________________________________________

10. If the student is not a new first-year or new transfer student, what and/or how has the student’s medical status changed that requires this request? ____________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

11. If the student has a respiratory condition, can it be accommodated by the use of an air purifier? ____________________________________________
____________________________________________________________________________________

The information provided above is true and accurate.
Signature of Physician/Mental Health provider: ________________________________ Date: ________________________________

Physician/Mental Health Provider Name/Title (please print): ________________________________

Clinic/Hospital Name, Town/City, State: ____________________________________________
Phone: ________________________________
FAX: ________________________________

**DAKOTA STATE UNIVERSITY USE ONLY**

Date Received: _____________________ Request Reviewed By: __________________________

Request:  
☐ Approved Unconditionally  
☐ Approved with Conditions: ____________________________________________  
☐ Not Approved – Reason: ____________________________________________

Signature: ________________________________ Date: ________________________________