

Physician/Therapist Fills Out the Section Below – Please Print

The provider filling out this form cannot be a relative of the student. Please do not submit a prescription in lieu of filling out this form.

To determine eligibility for special housing, St. Mary's College of Maryland requires current and comprehensive documentation of the student's condition from a licensed health care provider or clinical professional who is familiar with the history and functional limitations of the student's condition(s). All items must be completed in full. If the space provided is not adequate, please continue on the back of the page. The physician/therapist 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 the above request: _____

 - 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 student 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. Are there any significant limitations to the student's functioning directly related to the prescribed medications? NO _____ YES (please describe) _____

5. Has the student ever been hospitalized as a result of the condition? If YES, 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_____
8. For allergy patients: Has the student been skin tested by an allergy specialist? If so, what were the results? _____
9. For asthma patients: Has the student 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. Are there possible alternatives if the above request is not possible? NO___ YES (please state): _____

The information provided above is true and accurate:

_____	_____
Signature of Physician/Therapist	Date
_____	_____
License Number	State

Please Print:

Physician/Therapist's Name/Title: _____
 Address: _____
 Phone: _____
 Fax: _____