



Medical Request for Use of Air Conditioner:

Student Name: _____ Date of Birth: _____

TO BE COMPLETED BY THE ATTENDING ALLERGIST, PULMONOLOGIST OR OTOLARYNGOLOGIST.

Your patient has requested the use of an air conditioner in their university housing location. Your professional opinion will be used in the consideration of this request. Special housing is limited and only those students with the greatest medical needs will receive special housing arrangements. In order to make this determination, it is important that the medical documentation is complete and supports the request.

1. Patient's diagnosis and related ICD-10 code(s):

2. Statement as to the level of severity and the activities (including athletic participation) impacted by the patient's condition:

3. Current treatment plan, including asthma action plan, medications, therapies and interventions:

4. Please attach results of any diagnostic testing along with a copy of your most recent History and Physical.

5. Symptoms are: ☐ Continuous ☐ Intermittent ☐ Seasonal

6. Can an air purifier be substituted for an air conditioner?

☐ Yes ☐ No

Physician's Name (please print)

Signature

Physician's Specialty

Date

Physician's Office Phone Number