Caltech

Caltech Accessibility Services for Students (CASS)
Phone: 626-395-2961
Email: cass@caltech.edu

Documentation of Allergy, Asthma, and/or Dietary-Based Disability

Caltech complies with federal and state disability laws that prohibit discrimination and require that universities ensure equal access for qualified persons with disabilities to educational programs, services and activities. Medical providers can complete this form to assist Caltech Accessibility Services for Students (CASS) in determining eligibility and appropriate and reasonable disability accommodations.

With regard to specific housing as a disability accommodation, Caltech has a limited number of residence halls that are relatively new and/or air filtered or air conditioned. We make our best effort to ensure that students with the most significant disabilities have a medically appropriate placement so that they can actively participate in Caltech's educational programs and activities.

Caltech offers many dining options capable of accommodating many different dietary needs, including but not limited to gluten-free, vegan options and kosher dining, in addition to a wide array of healthy eating choices. Ordinarily, undergraduate students living in Caltech housing are required to be on a board plan.

Student's Name: _____

Diagnos(es): _____ Date of Diagnosis: _____

Date Student was Last Seen/Name of Professional:

_____

_____

Check the following that apply to this student:

_____ Was treated in the emergency room for this condition within the last year
_____ Has received in-patient treatment for this condition within the last year
_____ Prescribed allergy shots
_____ Prescribed short acting rescue inhaler
_____ Uses an epinephrine pen (i.e. Epi-pen)
_____ Recommended to use oral maintenance medications (including antihistamines, leukotriene inhibitors)

Describe how the above condition(s) substantially limits a major life activity that the average person in the general population can perform with little or no difficulty, and the condition(s) impact(s) on the student's daily life experience in the post-secondary setting:

Recommendations for health care and symptom management for the above condition while on campus:

List any medical/therapeutic equipment needed (if applicable):

Please feel free to attach additional information about student's condition, and fill out the appropriate section(s) on the following page pertaining to the relevant disability(ies).

For Asthma, is it:

____Mild intermittent ____ Mild persistent ____ Moderate persistent ____ Severe persistent

What specifically induces asthma attacks for this student:

Recommendations to the student for asthma management:

For Environmental Allergy(ies), please list specific allergens:

 Please indicate severity of environmental allergies for this student:

____ Mild   ____ Moderate   ____ Severe

Recommendations to the student for allergy management:

For Food Allergies, please list specific allergens:

The following exposures trigger a food allergy reaction: ____ airborne particles ____ skin contact
____ ingestion ____cross-contact ____ Other (please describe):

The food allergies trigger the following reactions: ____Anaphylaxis ____ Angioedema ____ Rash
____ Gastrointestinal symptoms ____ Other (please explain):

Procedures/assessments used to diagnose (please attach copies of assessment results used in making/ confirming diagnosis): ____ Spirometry ____ Allergy Testing
____ Evaluation by allergy/asthma specialist ____ Other (please explain):

If the student has medically necessary dietary needs, please indicate which modifications you believe are necessary, and explain how this alternative to the standard meal plan would affect the student's underlying condition:

	Access to the Gluten-free section (including baked goods, soups, sandwiches, etc)
	Access to the Dairy-free menu options
	Specialized diets for Gastrointestinal Diseases (e.g., Crohn's, Colitis, IBS)
	Specialized diets for Diabetes
	Menu planning consultation with Dining Services Staff
	Bulk purchasing program
	Other (please describe the dietary access modification you believe is necessary):

CERTIFYING PROFESSIONAL

Name: _____

Signature: _____ Today's date _____

License: _____ E-mail: _____

Telephone: _____ Fax: _____

Address: _____

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4 of 4