South Dakota State University
Request for Medical Exemption to SD Board of Regents Housing Requirement
Supplemental Medical Need Verification Form

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

Please have your physician complete their part of this form and return it to the address listed at the end of this document. A prescription form or brief memo does not include sufficient information for our review process and will be returned.

Special points:
- Single rooms are very limited.
- Purchase of an air purifier and/or humidifier is the responsibility of the student.

In order to evaluate a student’s needs for exemption to housing, the University requires specific diagnostic information from a licensed health care provider or clinical professional. This physician 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 complete and sign the Permission to Release Information. This signature allows the physician to provide information to the University, and allows the appropriate and qualified South Dakota State University staff members, permission to discuss the student’s condition or resulting determination with the physician completing this form. The provider must complete the pages, sign, and return the completed packet to:

Mail: South Dakota State University
Housing & Residential Life
Box 2810A
Caldwell Hall
Brookings, SD 57007
Fax: (605)688-6044

Student’s Name: ________________________________
Student SDSU ID#: ____________________________
Phone Number: ________________________________
Address: ________________________________
          (Street Address/PO Box/Residence Hall and Room)  (City)  (State/Zip)

I give Dr. __________________________ of the __________________________ Medical Clinic/Center permission to release to South Dakota State University any and all relevant medical information needed for the medical release for which I am applying. I also authorize my physician to discuss my condition(s) with the appropriate and qualified SDSU personnel on an as needed basis.

Student Signature: ____________________________ Date: __________________________

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Physician Completes the Following Section

The following section is to be completed by the Doctor/Health Care Provider. If the space provided is not adequate, please continue on the back of the page. Attach additional information as necessary. All items must be completed in full. Partial or illegible responses will result in it being returned to the student/physician for clarification.

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

1. How long have you known this patient? 

2. What specific issues pose an imminent risk making it medically necessary for this student to consider options other than living in an on campus residential environment that supports the student which may include living in the University Apartments? State the symptoms and actual condition/diagnosis and explain in lay terms the medical/psychological rationale for how the condition(s) might affect the student’s living situation:

   a. How often have you seen this person in the past 6 months for this specific condition? 
   b. How long has the patient had this condition? 
   c. What is the severity? 
   d. How long is this condition likely to persist? 
      i. What treatment(s) have been applied? 
         1. Proven to be successful? 
         2. Needed improvement? 

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

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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

South Dakota State University offers multiple housing options for students. The following
buildings have centralized air-conditioning: Schultz, Ben Reifel, Hyde, Abbott, Thorne, Spencer,
Honors, Caldwell, and Brown. Every residence hall is air-conditioned with either central air or
with window air units.

All buildings are smoke-free.

All public areas are vacuumed every day and all lavatories are cleaned and disinfected on a daily
basis at a minimum when the University is open. Annually, air filters in student rooms are
replaced and central ventilation filters are changed twice. All rooms in the system are equipped
with operational windows. Students are responsible for cleaning their own rooms, including
vacuuming and dusting as needed and restrooms are applicable as assigned.

Therefore, it has been determined that allergies, generally are NOT a legitimate reason to be
excused from the residence halls or apartments. Such request 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 a furnished residence hall room or
   apartment) that this patient would have an allergic reaction to: ________________________________
   __________________________________________

9. For asthma patients: Has the patient ever required prednisone or any other medications 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 condition changed that requires this request?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

11. The South Dakota Board of Regents expects SDSU to make reasonable accommodations for students with disabilities and health issues. What accommodations might the University and or Student make in order for this student to be able to live in University Apartments or Residence Halls? (Check all that apply)
   a. Apt./ Room on first floor_______
   b. Wheelchair accessibility_______
   c. HEPA Air Filter Machine_______
   d. Humidifier_______
   e. Orthopedic mattress_______
   f. Central air-conditioned facility_______
   g. Close to restrooms (in residence halls)_______
   h. Other (Please explain):________________________________________________________________________

________________________________________________________________________

12. What specific medication or equipment is required which would affect placement or room designation?

________________________________________________________________________

________________________________________________________________________

13. If off campus accommodations are stipulated, what recommendations are you making that will help accommodate this medical condition?

________________________________________________________________________

________________________________________________________________________

14. How will off campus accommodations be more beneficial then campus rooms or apartments that might have same or similar provisions?

________________________________________________________________________

________________________________________________________________________
Medical Professional: I understand that medical releases are based on significant (NOT JUST IMPORTANT, BUT EXTREME IN NATURE) or unforeseen medical conditions. The information I have submitted is accurate and should be taken into consideration when reviewing this student’s record. I further understand that this information may be presented to the SDSU Student Health and Counseling Services or referral physicians or a certified mental health provider.

Doctor/Health Care Provider Signature: ___________________________ Date: ____________
Please print your name: ______
_________________________________________ Phone: ____________
_________________________________________ Clinic/Hospital: ______
_________________________________________