

Disabilities Support Services (DSS)  
University of Delaware  
325 Academy Street, Suite 161  
Newark, DE 19716  
USA



Phone: (302) 831- 4643  
Fax: (302) 831-3261  
TTY: (302) 831-4563

## REQUESTS FOR RELEASE DUE TO MEDICAL, PSYCHOLOGICAL, OR DISABILITY NEEDS

The learning environment and residential living are central to the University of Delaware experience. Housing Assignment Services refers or forwards all medical, psychological or disability related requests for release to live off campus to the Americans with Disabilities Act (ADA) Office. This information is kept confidential and is used to evaluate requests while evaluating each individual situation. To aid this process, requests should include:

- This completed documentation form
- Any other relevant information you feel is necessary

Students who request release from the Academic Year Student Housing Agreement will be considered for release if the medical need cannot be accommodated by available on-campus vacancies. Requests must be accompanied by relevant and substantial supporting documentation provided by a certified medical professional. This documentation consists of an evaluation by an appropriate professional that relates the current impact of the condition to the request for release and what the off-campus facilities can provide that cannot be accommodated on campus. The documentation and Request for Release form will be verified by the DSS Coordinator or a medical statement may also be provided by the Student Health Service.

For complete details regarding the Academic Year Student Housing Agreement, please see <http://www.udel.edu/has/housingagreement.html>.

In order to evaluate your request for release, you must complete this form and sign the Authorization to Receive Health Care Information below. This gives us permission to speak with your examiner if we have questions relating to his/her recommendation for accommodation(s). Your health care provider must complete the rest of this form, sign it, and return the completed packet to the above address.

In addition to the basic documentation about a medical condition, further recommendations from the Professional are welcome and will be given consideration in evaluating a request.

Factors we consider when evaluating requests for release from on campus housing:

- Is the impact of the condition life-threatening if the request is not met?
- Is there an available on-campus space that meets the needs of the medical condition of the student?
- Can an on-campus space be adapted without creating a safety hazard if a student remains on campus?

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### STUDENT SECTION (Please print or type)

Housing Application Academic Year: \_\_\_\_\_ Date: \_\_\_\_\_

Student Name (last, first, middle):

\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

New Freshman \_\_\_\_\_ Returning Student \_\_\_\_\_ Transfer Student \_\_\_\_\_

Current Campus Address (if applicable) \_\_\_\_\_

Home Address:

\_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**AUTHORIZATION TO RECEIVE INFORMATION**

I authorize the University of Delaware, DSS Office, to receive information from the professional who fills out the Housing Documentation Form, and for him/her to discuss my condition(s) with the DSS Office if necessary.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL PROFESSIONAL SECTION**

*This section is to be completed by the student's healthcare provider.*

Student's Name: \_\_\_\_\_

Current medical condition/diagnosis:

\_\_\_\_\_  
\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_ Please check: Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe \_\_\_\_\_

Expected duration of the condition: Temporary \_\_\_\_\_ Permanent \_\_\_\_\_ Stable \_\_\_\_\_ Progressive \_\_\_\_\_

Describe the symptoms related to the medical condition that cause significant impairment to a major life activity (i.e. walking, breathing, sleeping, seeing, hearing, learning, socializing). Please relate it to student housing accommodations:

\_\_\_\_\_  
\_\_\_\_\_

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List the current medication(s) the student has been prescribed and any adverse side effects.

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Are there significant limitations to the student's functioning directly related to the prescribed medications?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe.

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If medication treatments are successful, why is the request for release necessary?

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Why is this student unable to live in campus housing? Please describe reasons and provide medical foundation for the reasons.

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Will this student be living at home or in an off-campus housing facility? \_\_\_\_\_

How will this living situation better accommodate the student's medical needs?

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Would any of the following accommodations allow for this student to continue to live in campus housing?

Air Conditioning	Y	N
Single Room	Y	N
Centrally Located	Y	N
Close to Dining Facilities	Y	N
Kitchen Available	Y	N
Wheelchair Accessible	Y	N
In-Room Private Bath	Y	N
Limited Stair Climbing	Y	N
Personal Aid Required	Y	N
Other (Please List)		

Name of Professional (please print): \_\_\_\_\_

Signature of Professional:

\_\_\_\_\_ Date: \_\_\_\_\_

License #: \_\_\_\_\_ State: \_\_\_\_\_

Address:

\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_