Black Hills State University
Housing Contract Exemption & Appeal

Supplemental Qualifying Medical Condition Verification Form

Student Name:_____ Student ID #:_____

Student Address:_____
(Street Address/PO Box/ Residence Hall and Room) (City) (State) (ZIP)

I give Dr. _____ of the _____
Medical Clinic/Center permission to release to Black Hills State University any and all relevant medical information needed for the medical release for which I am applying.

Student Signature:_____ Date:_____

The following section is to be completed by a Doctor/Health Care Provider. Attach additional information as necessary.

Describe the specific medical condition for which this release is being requested.

What specific issues pose an imminent risk making it ***medically necessary*** for this student to consider options other than campus housing?

The South Dakota Board of Regents expects BHSU to make reasonable accommodation for students with disabilities and health issues. What accommodations might the University make in order for this student to be able to live in campus housing?

____ Air-conditioned facility
____ Wheelchair accessibility
____ Campus Suite*
____ Room on first floor
____ Private Room
____Other (Please explain)
____ Close to restrooms
____ Mattress (Bring Own)

_____
_____
_____

*The Campus Suites provide for a greater level of student privacy on campus. Each air-conditioned 3 person Campus Suite includes 2 bedrooms (1 single, 1 double), kitchen, common room, and bathroom.

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

If the University cannot accommodate this student on-campus, what kind of off-campus housing would you recommend that would help alleviate or accommodate this medical condition?

Other Comments:

I understand that medical releases are based on significant 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 BHSU Student Health Services and/or the BHSU Student Counseling Center.

Attending Physician's Signature:_____ Date:_____

Please print your name:_____ Phone:_____

Clinic/Hospital:_____