

**McDaniel College**  
**Special Housing Considerations Request Instructions**

Please read all of the following steps before making a request for special housing considerations.

In compliance with the Americans with Disabilities Act, Residence Life offers accommodations to students with disabilities when appropriate. Students with physical (e.g., wheelchair users, mobility impairments) and/or sensory (e.g., blind, deaf) disabilities should contact Residence Life to ensure accessible housing. They will also need to provide documentation as requested by Residence Life. Students with specific medical or psychological concerns may request special housing circumstances (i.e., a single room or permission to bring an AC unit). However, these requests must be evaluated and approved by the appropriate College department (i.e. Health Services or Counseling Services of the Wellness Center, or Student Academic Support Services). With limitations of space, electrical power, and other considerations, every attempt will be made to honor valid requests, although there is no guarantee that the special request will be accommodated.

In order to submit a request, students must complete the following steps and submit all forms and documentation together to the Office of Residence Life:

1. The Special Housing Considerations Request form must be completed, signed, and dated.
2. A letter, supporting the need for special housing considerations, must be completed by the student's licensed treatment provider. This documentation should be a comprehensive written evaluation, using common language, and it must be provided by a licensed treatment provider (such as a general medical practitioner, psychiatrist, or psychologist). In addition, the documentation, diagnosis, and treatment must be dated within the past 4 months (normally one semester). The evaluation should include:
  - a. The examiner's name, address, phone number, credentials, and licensing number.
  - b. Full diagnosis (including a multi-axial DSM-V diagnosis, if applicable)
  - c. A summary of the treatment provided (as it relates to the condition and the student's need for accommodations)
  - d. Current medications and dosage, as well as past medication within the last 4 months (if different from current medicine)
  - e. Detailed explanation describing how the condition impairs normal functioning and/or academic functioning on a college campus, as related to the requested accommodation
  - f. Current treatment and date of last appointment with the student
  - g. Any recommendations for continued treatment
3. If the request involves a psychological concern, two releases of information (see forms attached) must be completed and signed for the Wellness Center. The first form authorizes Wellness Center Staff to exchange information about the request with the Office of Residence Life. The second form must be completed with the full name and contact information of the treatment provider who has provided evaluation documentation. This authorizes Wellness Center Staff to exchange information that is pertinent to processing the request with that treatment provider.

\*Students may also be asked to meet with College staff, or to submit other documentation, in order to provide the information needed to process their request. Students will be contacted if this becomes necessary.

All paperwork can be faxed to the Office of Residence Life at 410-857-2773 or scanned and emailed to [reslife@mcDaniel.edu](mailto:reslife@mcDaniel.edu). If you have any questions please contact the Office of Residence Life (410-857-2240), the Wellness Center (410-857-2243), or Student Academic Support Services (410-857-2504).

**McDaniel College Wellness Center  
Counseling Services**

**Authorization to Release Medical Record Information**

I, \_\_\_\_\_, hereby authorize the McDaniel College Counseling Services to:

\_\_\_\_\_ release to: \_\_\_\_\_ obtain from: \_\_\_\_\_  exchange with:

\_\_\_\_\_ McDaniel College Office of Residence Life \_\_\_\_\_

**the following information pertaining to myself:**

\_\_\_\_\_ **Dates of Treatment**

\_\_\_\_\_ **Student Progress**

\_\_\_\_\_ **Psychiatric Evaluation**

**Assessment and Recommendations**

\_\_\_\_\_ **Compliance with Treatment**

**Other** (please specify) Information pertinent to student's request for special housing consideration

**for the purpose of:**

\_\_\_\_\_ **Academic Considerations**

\_\_\_\_\_ **Administrative Policies** (Including, but not limited to, authorization to return to McDaniel College following a mandatory off-campus psychiatric evaluation, hospitalization or medical leave, or compliance with mandatory treatment.)

\_\_\_\_\_ **Compliance with McDaniel College Judicial Sanctions**

\_\_\_\_\_ **Contact with Referral Sources/Coordination of Treatment**

\_\_\_\_\_ **Family Involvement**

**Other** (please specify) To coordinate student's request for special housing consideration

I understand that I am giving permission to the McDaniel College Counseling Services for disclosure of confidential medical record information. I also understand this is a professional and confidential exchange and that it may occur in written and/or oral form. I also understand I have the right to revoke this consent at any time, and must do so in writing. A copy of this consent will be kept in Counseling Services' electronic medical record software. This release of information will expire at the end of this current academic semester unless another date is specified. Alternate expiration date of authorization (if applicable) \_\_\_\_\_.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Birth

**McDaniel College Wellness Center  
Counseling Services**

**Authorization to Release Medical Record Information**

I, \_\_\_\_\_, hereby authorize the McDaniel College Counseling Services to:

\_\_\_\_\_ release to: \_\_\_\_\_ obtain from: \_\_\_\_\_  exchange with:

Off-Campus Mental Health Care Provider: \_\_\_\_\_

Contact information: \_\_\_\_\_

**the following information pertaining to myself:**

- Dates of Treatment**
- Progress**
- Psychiatric Evaluation**
- Assessment and Recommendations**
- Compliance with Treatment**
- Other** (please specify) Information pertinent to student's request for special housing consideration

**for the purpose of:**

- Academic Considerations**
- Administrative Policies** (Including, but not limited to, authorization to return to McDaniel College following a mandatory off-campus psychiatric evaluation, hospitalization or medical leave, or compliance with mandatory treatment.)
- Compliance with McDaniel College Disciplinary Sanctions**
- Contact with Referral Sources/Coordination of Treatment**
- Family Involvement**
- Other** (please specify): To coordinate student's request for special housing consideration

I understand that I am giving permission to the McDaniel College Counseling Services for disclosure of confidential medical record information. I also understand this is a professional and confidential exchange and that it may occur in written and/or oral form. I also understand I have the right to revoke this consent at any time, and must do so in writing. A copy of this consent will be kept in Counseling Services' electronic medical record software. This release of information will expire at the end of this current academic semester unless another date is specified. Alternate expiration date of authorization (if applicable) \_\_\_\_\_.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Birth

## McDaniel College Special Housing Considerations Request Form

Students requiring special equipment (i.e. an Air Conditioner or extra refrigerator) or who have special housing circumstances due to specific medical or other concerns must be evaluated and approved by the Student Health Center staff, Counseling staff, or Student Academic Support Services. Within limitations of space, electrical power, and other considerations, every attempt will be made to honor valid requests, although there is no guarantee that the special request will be accommodated.

**NOTE:** Requests from **new students** must be submitted and verified by **June 1st** for consideration.  
Requests from **returning students** must be submitted by Housing Deposit deadline for consideration for the upcoming Fall. Please see information online or contact Residence Life at 410-857-2240 for this date for the current year.

Along with this form, please submit your accompanying letter and medical documentation from your licensed treatment provider. The documentation must be dated within the past 4 months, and follow all guidelines described in the instructions provided with this form. If the request involves a psychological concern, please also submit the two releases of information.

**To be completed by student:**

<b>Last Name:</b>		<b>Email:</b>		<b>Cell Phone:</b>	
<b>First Name:</b>		<b>Student ID #:</b>		<b>Other Phone:</b>	
<b>Anticipated Graduation Date:</b>		<b>Gender:</b>			

Requesting:       Air Conditioning (could be accommodated by College provided window unit)  
                           Single Room  
                           Other: \_\_\_\_\_

Brief summary of reason for request: \_\_\_\_\_

I hereby authorize the use or disclosure of my protected health information for the purpose of follow-up in Student Health Services, Counseling Services, and/or Student Academic Support Services. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

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

.....  
**To be completed by the College Staff:**

Date Request Received: \_\_\_\_\_ Received By (Name): \_\_\_\_\_  
 Office Paperwork Sent to for Referral: \_\_\_\_\_ Date Sent: \_\_\_\_\_

Counseling/Health Services/SASS Staff member: \_\_\_\_\_

Date of consultation/verification: \_\_\_\_\_

Consulted/verified with: \_\_\_\_\_

Recommendation:       Approve request (medically required)  
                                   Denied request (not necessary)

Student to be re-evaluated (circle one):      Annually                      Not Necessary

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_