

Medical History Self-Report

Fall 2025 Admission | Supplemental Application Materials

Fall 2025 Applicants

If you are applying to AHRC New York City's [Melissa Riggio Higher Education Program](#) at the City University of New York in partnership with the new [CUNY Unlimited](#) credential program, please complete this questionnaire regarding your medical history. All information will be kept confidential. This information will be used for the evaluation of your health and readiness to participate in the Melissa Riggio Higher Education Program.

As you complete the Medical History Self-Report, please be sure to read carefully and answer as accurately as possible. Submit the completed form with all other Supplemental Application Materials directly to AHRC New York City's Referral and Information Center. For more information, visit www.ahrcnyc.org/services/school/college/apply. The Application Deadline for Fall 2025 Admission is December 1, 2024.

Applicant Information

First Name	Middle Initial	Last Name
Residential Street Address (Where you are living right now)		
City	State	Zip Code
Mailing Street Address (If different from your residential address)		
City	State	Zip Code
Signature of Applicant		Date

Primary Contact Information

Full Name
Relationship to Applicant
Phone Number
Email Address

Secondary Contact Information

Full Name
Relationship to Applicant
Phone Number
Email Address

AHRC New York City reaffirms its policy of equal opportunity and does not discriminate against any applicant because of race, color, sex, age, national origin, religion, sexual orientation, gender identity, status as a veteran, and the basis of disability or any other federal, state or local protected class.

Medical History Self-Report (Cont'd)

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1. Please provide a brief description of your medical history, including any disability diagnoses that you may have.

2. Please list any significant medical or physical conditions that may impact your participation in classroom, social, or recreational activities on campus, including severe allergies.

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3. Please list any current medications and indicate what usage the medications are for.

4. Are you able to self-administer your own prescription medications?

☐ Yes

☐ No

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5. Do you currently receive private therapeutic services, such as physical therapy, occupational therapy, psychiatry, speech therapy, or counseling? If so, please indicate which services.

6. Are you independent in self-care such as toileting, and basic hygiene?

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- 7. Please provide any other medical information that you feel would be important regarding your participation in this program.**