Medical History Self-Report

For applicants to AHRC New York City's Melissa Riggio Higher Education Program at the City University of New York, in partnership with CUNY Unlimited.

Instructions

Please complete this medical history questionnaire. Your information is confidential and will be used only to assess your health and readiness to participate in the program. Read each question carefully and answer as accurately as possible. Submit the completed form, along with all other supplemental application materials, directly to AHRC New York City.

For current deadlines and detailed application information, visit www.ahrcnyc.org/services/get-an-education/college/apply.

Applicant Information

First Name | Middle Name | Last Name

Residential Street Address *(Home address)*

City | State | Zip Code

Mailing Street Address *(If different from your home address)*

City | State | Zip Code

Signature of Applicant | Date of Signature

Primary Contact Information

First Name | Last Name

Relationship to Applicant

Phone Number

Email Address

Secondary Contact Information

First Name | Last 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 on the basis of race, color, sex, age, national origin, religion, sexual orientation, gender identity, veteran status, disability, or any other category protected by federal, state, or local law.

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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.