MEDICAL HISTORY

Please attach results of a current (within 1 year) physical exam along with this document. Please note upon acceptance Immunization Records must be submitted to University Health Services for acceptance to Appalachian State University.

Please answer the following additional questions:

Please give a brief description of your medical history including any disability diagnoses that you may have:

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

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

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Please list any current medications and indicate for what the medications are taken:

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Note: If the applicant must take medications while on campus, he/she must be independent in administering his/her medications. ASU and the SDAP Program do not have the personnel to administer medications.

Do you currently receive private therapeutic services, such as physical therapy, occupational therapy, psychiatry, speech therapy, behavioral therapy? If so, please indicate which services:

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Note: Any of these services needed by the student while enrolled at ASU must be provided at the expense of the parent.
Are you independent in self-care such as toileting, and basic hygiene (including bathing, dressing, eating, menstrual care, etc.)?  Yes  No

List any limitations

Note: If not, the applicant will need to arrange for personal assistance services in order to attend the SDAP Program at ASU. This is not included in any of the program or college services.

Are there any limitations, support needs or related issues to housing? (Please list)

Are there any limitations, support needs, or other related issues to public transportation? (Please list)

Note: The applicant may need to seek additional personal support for some housing and living situations depending on the need. The SDAP Program and Appalachian can only supply basic accommodations.

Please provide any other information that you feel would be important regarding your participation in this program:

__________________________________________________________________________

__________________________________________________________________________

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__________________________________________________________________________
Medical Insurance

All students at Appalachian are eligible to purchase health insurance through the University. While enrollment in the Appalachian State Health Care Insurance Program is NOT mandatory, but proof of insurance coverage is required by the University.

Please provide a copy of your health insurance card (front and back) along with this form:

Student Name: ________________________________
Last 4 digits of SSN: ________________________________

Certification/Proof of Health Insurance Coverage

Name of Policy Holder: ________________________________
Health Insurance Company: ________________________________
Health Insurance Company Phone Number: ________________________________
Policy Number: ________________________________

Guardian Signature: ________________________________
Student Signature: ________________________________