

Dear Prospective Resident,

Before returning your housing packet, please be sure that you have completed all the items listed below. Once we have received all of your information, we will reserve a room for you.

\_\_\_\_\_ **Housing and Boarding Contract** must be filled out completely, dated and signed on the correct line of page 2.

\_\_\_\_\_ **Residence Hall Assignment Application** accurately completed.

\_\_\_\_\_ **Personal Medical History Form** accurately completed.

\_\_\_\_\_ **Health and Accident Insurance Form** accurately completed and signed.

\_\_\_\_\_ **Housing Deposit of \$50.00 and Room Breakage Fee of \$100.00** enclosed.

\_\_\_\_\_ **Student Clearance Form** accurately completed by all parties involved.

Thank you in advance for your cooperation, and welcome to West Virginia State University!

Sincerely,

Cornelious Jones, Director  
Residence Life & Services

**PLEASE RETURN HOUSING PACKET TO:**

West Virginia State University  
Residence Life & Services  
138G Prillerman Hall  
P.O. Box 1000  
Institute, WV 25112-1000



Please indicate how you will be meeting your financial obligations to the university: (check all that apply) Self Pay \_\_\_\_\_ / Financial Aid \_\_\_\_\_ / AMS \_\_\_\_\_ / 60/40 pay plan \_\_\_\_\_ / 50/50 pay plan \_\_\_\_\_ / Scholarship \_\_\_\_\_ (please indicate type) \_\_\_\_\_ / Other (please indicate) \_\_\_\_\_

Roommate Requests: 1. \_\_\_\_\_ 2. \_\_\_\_\_

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I plan on participating in the Athletic Program Yes / No

I plan on playing: (circle all that apply)

Baseball      Basketball      Football      Softball      Volleyball      Track/Field

Other: \_\_\_\_\_

Do you have or expect to receive a room waiver? Yes / No

Are you enrolled in the ROTC Program? Yes / No

Do you have or expect to receive an ROTC room waiver? Yes / No

Environmental preferences: \_\_\_\_\_ Double Room \_\_\_\_\_ Single Room

**I understand that all requests are preferences and based upon availability.**

Check the hobbies and interests you enjoy:

_____ sports	_____ arts & crafts	_____ social issues
_____ cards	_____ reading/literature	_____ watching TV
_____ movies	_____ student government	_____ aerobics
_____ music	_____ walking/running/jogging	_____ others
_____ dancing	_____ academic discussion groups	_____ others
_____ photography	_____ residence hall council	_____ others

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FORWARDING ADDRESS (when you leave school - for mailing purposes)

If you want your mail forwarded you must make a request in the Residence Life Office or with your Resident Director. If time permits mail will be forwarded for 30- 60 days maximum, after that date all mail will be returned to sender.



stroke \_\_\_\_\_  
 asthma, hayfever,hives \_\_\_\_\_  
 epilepsy/convulsions \_\_\_\_\_  
 nervous/mental disease \_\_\_\_\_  
 Mother living? \_\_\_\_\_  
 Father living? \_\_\_\_\_  
 If any siblings are deceased, state relationship and cause of death: \_\_\_\_\_

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**PERSONAL HEALTH HISTORY**

Have you ever had or do you have any of the following: (In lines of multiple statements, cross out the inapplicable words.) Explain all positive answers.

CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO
heart trouble	___	___	tuberculosis	___	___
high/low blood pressure	___	___	stomach/intestine trouble	___	___
rheumatic fever	___	___	jaundice/liver diseases	___	___
diphtheria	___	___	appendicitis	___	___
mumps	___	___	rupture	___	___
whooping cough	___	___	skin disease, boils	___	___
measles	___	___	painful/trick shoulder	___	___
chicken pox	___	___	trick/ locked knee	___	___
mononucleosis	___	___	bone/joint deformity	___	___
wear glasses	___	___			
nose/throat trouble	___	___			
ear trouble	___	___			
sinusitis	___	___			
chronic/frequent colds	___	___			
hay fever, allergies	___	___			
asthma	___	___			
reaction to serum/drugs	___	___			
chronic cough	___	___			
shortness of breath	___	___			

IF YOU RESPONDED YES TO ANY OF THE ABOVE OR HAVE HAD ANY DISEASES, PLEASE GIVE DETAILS \_\_\_\_\_

HAS YOUR HEALTH BEEN: GOOD \_\_\_ FAIR \_\_\_ POOR \_\_\_ IF POOR EXPLAIN \_\_\_\_\_

<u>CHECK THE ITEM:</u>	<u>HAVE YOU:</u>	<u>YES</u>	<u>NO</u>
Ever had psychiatric evaluation or treatment?		___	___
Taken tranquilizers regularly?		___	___
Often taken pep pills or stimulatory drugs?		___	___
Had sickle cell?		___	___
Ever worn or do you wear a hearing aid?		___	___

WHEN YOU ENTER SCHOOL WILL YOU NEED TO:

	Yes	No
Take allergy shots?	_____	_____
Be seen by a doctor regularly?	_____	_____
Special housing considerations?	_____	_____
Be excused from physical activities?	_____	_____
Psychiatric consultation or therapy?	_____	_____
Any surgical procedure?	_____	_____
Care for any existing injury?	_____	_____
IF YES, EXPLAIN.....		

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I certify that, to the best of my knowledge, the above information is complete and correct. I, hereby, grant permission to the Student Health Center or their consulting physicians to render emergency medical treatment that might be deemed necessary. When necessary for executing such care, I grant permission for hospitalization at an accredited hospital.

\_\_\_\_\_  
STUDENT SIGNATURE

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN  
(for minors)

\_\_\_\_\_  
DATE

HEALTH AND ACCIDENT INSURANCE FORM

STATEMENT:

The University is not liable, in the absence of negligence, for any medical bills, which result from injuries that occur in scheduled classes or university-sponsored activities or from sudden illness. Medical care exceeding the limitations of the Universities small Health Clinic can become a major problem to students without funds, available parents, or adequate insurance. It is also worth mentioning that the accident statistics of the 18-25 age group is high enough to strongly recommend health and accident insurance for every student. You should check to see if your child is covered under your personal insurance policy.

HEALTH AND ACCIDENT INSURANCE:

It is considered essential that every student be covered by some form of comprehensive health insurance. Insurance coverage is MANDATORY for all on-campus students unless the waiver application (attached) has been signed.

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**CERTIFICATIONS:**

Please complete one of the following certifications:

- (1) Personal Insurance Certification or
- (2) The Waiver Certification portion of this form and return the enclosed information to:  
WVSU - Residence Life & Services, 138G Prillerman Hall, P.O. Box 1000, Institute,  
WV 25112

**1: PERSONAL HEALTH INSURANCE CERTIFICATION:**

I, hereby, certify that the following information set forth by me on this form regarding my health insurance policy is correct, to the best of my knowledge, and I understand that falsification is caused for disciplinary action.

1. Name and Address of Insurance Company: \_\_\_\_\_  
\_\_\_\_\_  
Name and address of Insured: \_\_\_\_\_  
\_\_\_\_\_  
Policy or Contract # \_\_\_\_\_  
Signature \_\_\_\_\_  
Signature of Parent/Guardian (if student is under 18 yrs. Of age) \_\_\_\_\_  
\_\_\_\_\_

**2. NO HEALTH INSURANCE - WAIVER CERTIFICATE**

I, hereby certify, that I have read and understand the previous insurance information. I do not have a health insurance policy. I understand that the financial responsibility of the University is limited to routine health care with outside care at my personal expense if and when my illness/injury exceeds the limitations of the Universities Health Center.

Name (please print) \_\_\_\_\_  
Address \_\_\_\_\_  
number street  
\_\_\_\_\_  
City State Zip  
Signature \_\_\_\_\_ Date \_\_\_\_\_  
Signature of parent/Guardian (if student is under 18 yrs. of age)  
\_\_\_\_\_  
Date \_\_\_\_\_  
\_\_\_\_\_