

**AAFA-TX KAREEM BACCHUS MEMORIAL ACADEMIC
SCHOLARSHIP APPLICATION 2009-2010**

Part 1: This page is to be completed by applicant. Please **print legibly** in ink. Do not add additional pages unless requested. If application can't be read, it can't be evaluated. All requested information is required.

Name _____

Street address _____ City _____

State _____ Zip _____ email _____

Telephone _____ Birth Date: _____ Social Security #: _____

Name of High School _____

Complete Address of High School _____

Graduation date _____ USA citizen? Yes No Do you have legal USA residency? Yes No

Have you been accepted to a college or university? Yes No Student ID# _____

If yes, which one? _____

University address where we would send scholarship check if you are selected _____

Please list extracurricular activities, clubs, sports or student government participation in **past two years**

_____	_____
_____	_____
_____	_____
_____	_____

Please list **community service or work experience** plus any academic or **community honors or awards** with dates of service or award

In an accompanying letter, describe how your asthma has affected your life and how you have dealt with your asthma in school and in other aspects of your life. Include information about yourself, your goals and ambitions. Please limit the letter to no more than 1 typed page. In signing you agree the scholarship value is a one-time payment of \$1500 and if selected as recipient of this award, the funds will be paid to college or university of your choice.

Applicant's signature: _____ **Date:** _____

Application parts 3 & 4

Part 3: This part is to be completed by applicant's physician.

Physician's name _____

Address _____ City _____ Zip _____

Phone _____ Specialty _____

Applicant's Name _____

Does student have documented asthma? (circle one) Yes No Is patient compliant? Yes No

What classification and type of asthma does the patient currently exhibit?

___ Allergic ___ Exercise Induced ___ Infection Induced ___ Combination

___ Mild Intermittent ___ Mild Persistent ___ Moderate Persistent ___ Severe Persistent

Age at asthma onset? _____ Length of time under your care? _____

Current Medication Use (please check all that apply)

___ Short term inhaled Beta₂Agonists ___ Anticholinergics ___ Systemic Corticosteroids

___ Corticosteroids ___ Long-acting Beta₂Agonists ___ Leukotriene modifiers ___ None

Physician Signature _____ **Date** _____

Part 4: This part is to be completed by applicant's parent or guardian. Please write legibly and do not add additional pages.

Parent or Guardian's name _____ relationship _____

Address _____ City _____ Zip _____

Phone _____ email _____

Please provide information on financial need. AAFA-TX reserves the right to request support materials

I understand AAFA-TX will publicize winners of the scholarships and a senior picture will be provided for this intent.

Signature of parent or guardian _____ **Date** _____

PLEASE NOTE: All information provided is confidential. No financial information will be shared or publicized. Please send all questions to info@aafatexas.org Thank you.