Health Record Form

All students are required to file a current health record with Welch College at the time of enrollment.
This information is confidential. All sections must be filled out to be considered complete.
Please complete and return by mail to:

Welch College
3606 West End Avenue
Nashville, TN 37205
Phone 615-844-5000 Fax 615-269-6028

Check all that apply:
❒ Undergrad ❒ Nursing ❒ TE ❒ Dorm ❒ Commuter

Full Name _____ Gender ❒ Male ❒ Female
Last First Middle Preferred

Home Address _____
Street City/State Zip

Home Phone ( ) _____ Cell Phone ( ) _____ Email _____

Social Security No: _____ Birth Date _____

Initial Enrollment Term ❒ Fall ❒ Spring ❒ Summer 20____

Name of Parent, Guardian or Spouse (circle one) _____

Home Phone ( ) _____ Cell Phone ( ) _____ Email _____

Home Address _____
Street City/State Zip

Name of Emergency Contact (If other than above) _____

Home Phone ( ) _____ Cell Phone ( ) _____

HEALTH INSURANCE INFORMATION
Please provide copy of Insurance Card.

Name of Insurance Co. _____

Address/Phone# of Insurance Co. _____

Subscriber's Name/Relation to Student _____

Policy/ID No. _____ Group No. _____ Plan No. (if applicable) _____

❒ I am not currently covered by health insurance

(Over)

MEDICAL HISTORY

Have you had or are you experiencing any of the following: *(Please explain below)*

❒ Rheumatic Fever	❒ Anemia	❒ Cancer	❒ Heart Trouble	❒ Broken Bones	❒ Tonsillitis
❒ Difficulty with eyes	❒ Asthma	❒ Chest Pain	❒ Pneumonia	❒Hay Fever	❒ Jaundice
❒ High Blood Pressure	❒Chicken Pox	❒ Malaria	❒Frequent Headaches	❒ Whooping Cough	❒ Tuberculosis
❒ Seizures	❒Head Injury	❒Liver Disease	❒ Joint Trouble	❒ Chronic Cough	❒ Emotional Problems/Disorders
❒ Ear Infection	❒ Measles	❒ Pleurisy	❒ Stomach Trouble	❒ Back Trouble	❒Skin Trouble
❒ Foot Trouble	❒ Influenza	❒ Scarlet Fever	❒ Sinus Trouble	❒Mumps	❒ Glasses/Contacts
❒ Kidney/Bladder/Urinary tract Infections		❒ Diabetes Type I/II/or pregnancy induced		❒ Mononucleosis	❒ Other _____

Surgeries, Special Procedures, &/or Medical Treatment of Any Kind *(Explain type and dates)* _____

_____

Please e**xplain** any item marked above (please attach extra sheet if additional space is needed) _____

_____

_____

Please provide allergies or sensitivities ❒ none _____

_____

MEDICATIONS YOU ARE TAKING REGULARLY

List all prescribed and over the counter medications, including vitamins &/or herbs, body enhancing formulas, and diet pills

Name _____ *Dosage* _____ *Frequency* _____ *Reason* _____

Name _____ *Dosage* _____ *Frequency* _____ *Reason* _____

Name _____ *Dosage* _____ *Frequency* _____ *Reason* _____

Name _____ *Dosage* _____ *Frequency* _____ *Reason* _____

FAMILY HISTORY

Has anyone had or does anyone have any of the following in your immediate family: (Please explain below)

❒ Tuberculosis	❒ Epilepsy	❒ Asthma	❒ Allergies	❒ Cancer	❒ High Blood Pressure
❒ Heart Disease	❒ Diabetes Type I/II/pregnancy induces		❒ Other _____		

Explain _____

_____

Have you traveled or lived outside of the United States? ❒ No ❒ Yes If yes, list Location and Dates _____

_____

I affirm that any optional information withheld or erroneously reported will make it difficult to receive effective medical treatment and I therefore waive any liability on the part of Welch College related to absence or error in such information.

Name (print) _____ **Date** _____

Signature _____