WELCH COLLEGE

OFFICE OF THE REGISTRAR
1045 Bison Trail
Gallatin, TN 37066
Tel 615-675-5255
Fax 615-296-0400

RELEASE OF INFORMATION

PERSONAL INFORMATION (*Indicates required field)

*Name_____
Last First Middle Maiden

*SSN Last Four Digits _____ Welch Student ID# (if known) _____

*Date of Birth_____ *E-Mail_____

*Cell Phone _____ *Home Phone_____ Work Phone _____

*Currently enrolled: ☐☐ Yes ☐☐ No If "No": last date attended_____ or graduated _____

*HOME ADDRESS:

_____
Address

_____
City State Zip

*Check the item(s) you are authorizing us to release:

☐☐ Transcript:
- ☐☐ Official (standard): $5 per copy
- ☐☐ Unofficial

☐☐ Enrollment verification
☐☐ Degree earned, dates attended/graduated, G.P.A.
☐☐ Letter of good standing
☐☐ Other _____

*SEND INFORMATION TO:

1. _____
Institution

_____
Department / Attn:

_____
Address

_____
Address

_____
City State Zip

2. _____
Institution

_____
Department / Attn:

_____
Address

_____
Address

_____
City State Zip

Special Instructions/additional notes: _____
_____
_____

*Your Signature:_____*Date: _____

NOTE: This form requires student's signature, on original or facsimile. All transcript payments are nonrefundable. If an individual has a hold (e.g., financial), Welch College cannot release his/her transcript until that hold is cleared. If an individual has a question about this, he/she should contact the Registrar's Office.

For Office Use Only:
Date Request Received: _____
Date Sent: _____
Transcript Fee: Amount Paid: $_____

Welch College: Graduate Office
1045 Bison Trail
Gallatin, TN 37066
Phone: (615) 675-5255 Fax: (615) 296-0400

Full legal name _____
Last First Middle Maiden (if applicable)

Mailing Address_____
Street Apartment Number

Telephone_____ City, State _____ Zip Code _____

Email_____

Welch College is committed to upholding the provisions of the Family Educational Rights and Privacy Act. In compliance with this act Welch College will release no information prohibited in this act without your express, written consent or as permitted by law. If you would like your grades to be shared with any individuals or allow the College to communicate with any individuals (parents, spouse, financial representative, etc.) related to information about your matriculation at Welch College you must complete and submit the lower portion of this form.
By signing below you indicate your awareness and acceptance of this policy.

1) Authorization of Grade Disclosure

I hereby authorize Welch College to release my grade reports for the upcoming academic year, to my parents, legal guardian, or other named individuals or entities listed below. NOTE: *If parents live at different addresses, please list them both.*

Last Name First Name

Address

City State Zip

Last Name First Name

Address

City State Zip

Will share my Populi password with parent(s), legal guardian or other named individuals listed above.
(initial one) _____yes _____no

2) Family Educational Rights and Privacy Act Consent:

Parent/legal guardian or other named individuals or entities listed here may receive any information related to my college matriculation. **(* For students under age 25 still on parents IRS Form 1040, initialing "No" will result in notification of your custodial parent that you have chosen not to release information to them.)**
(initial one) _____yes _____no

3) Signature Section: I understand that by signing this authorization, ***I am consenting to the release of the education records listed to the persons specifically listed.*** This release does not permit the disclosure of these records to any other persons or entities without my written consent or as permitted by law.

Date

Student Name (Printed)

Student Signature

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
1045 Bison Trial
Gallatin, TN 37066
Phone 615-675-5255 Fax 615-296-0400

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 _____

HEPATITIS B
Waiver of Immunization

Hepatitis B (HBV) is a serious viral infection of the liver that can lead to chronic liver disease, cirrhosis, liver cancer, liver failure, and even death. Hepatitis B vaccine is available to all age groups to prevent Hepatitis B viral infection. A series of three (3) doses of vaccine are required for optimal protection. Missed doses may still be sought to complete the series if only one or two have been acquired. The HBV vaccine has a record of safety and is believed to provide lifelong immunity in most cases.

I have read the information provided about Hepatitis B disease, vaccine, and have made an informed decision to decline receipt of the vaccine.

Signature _____ **Date** _____
Signature of student or parent/guardian (if student is under 18)

Return to: Enrollment Management, Welch College, 1045 Bison Trail, Gallatin, TN 37066
Contact Information 615-675-5255, Fax 615-296-0400, email: recruit@welch.edu

Immunization Record

Parts A-E are required for all students. Part F is required for all dorm residents.

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

Full Name _____
Last First Middle Preferred

Home Address _____
Street City/State Zip

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

Birth Date _____

A. MEASLES, MUMPS, AND RUBELLA (check one)

REQUIRED OF ALL STUDENTS

❒ Attach a copy of Immunization record showing two (2) doses of Measles, Mumps & Rubella (MMR) vaccine.
❒ Attach copy of immune MMR titer. Date: ___/___/___ Results _____
The state of Tennessee requires all students, born after January 1, 1957, entering colleges and universities to provide proof of two (2) doses of Measles, Mumps, and Rubella (MMR) vaccine on or after the first birthday or proof of immunity to measles with an MMR titer (blood test).

B. VARICELLA OR "CHICKENPOX" (check one) -

REQUIRED OF ALL STUDENTS

❒ Attach a copy of Immunization record showing two (2) doses of varicella vaccine.
❒ Attach copy of immune varicella titer. Date: ___/___/___ Results _____
❒ Attach letter from health care provider stating that he/she believes student has had chickenpox.
Year of illness: _____

C. TETANUS/DIPHTHERIA (TD)

REQUIRED OF ALL STUDENTS

Last dose must be within 10 years of admission.
❒ Attach a copy of Immunization record showing one dose within past 10 years of admission.

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(Over)

D. HEPATITIS B (HBV) IMMUNIZATION - *RECOMMENDED* FOR ALL **NEW STUDENTS**

REQUIRED FOR STUDENTS IN **PRE-NURSING** AND **TEACHER EDUCATION**

Hepatitis B (HBV) is a serious viral infection of the liver that can lead to chronic liver disease, cirrhosis, liver cancer, liver failure, and even death. Hepatitis B vaccine is available to all age groups to prevent Hepatitis B viral infection. A series of three (3) doses of vaccine are required for optimal protection. Missed doses may still be sought to complete the series if only one or two have been acquired. The HBV vaccine has a record of safety and is believed to provide lifelong immunity in most cases.

❒ I decline receipt of vaccine to protect for Hepatitis B—**attach a copy of waiver.**
❒ I have received the complete three dose serves of the Hepatitis B vaccine. Attach a copy of Immunization record showing three (3) doses of Hepatitis B vaccine.
❒ I plan to receive the Hepatitis B series.

E. TUBERCULOSIS (TB) SCREENING (must be within 12 months prior to enrollment)

REQUIRED OF ALL STUDENTS

Option 1 or 2 is ***REQUIRED*** for ALL NEW students. Option 1 is ***REQUIRED*** for all **Pre-Nursing** and **Teacher Education** students.

Option 1: PPD (TB skin test) or Interferon Gamma Release Assay (IGRA)
Attach a copy of results.
Option 2: Fill out the TB Assessment Form (separate form) and sign the bottom. If you have risk factors, an appropriate TB screening test is required.

TB Risk Screening

Persons with any of the following risk factors are candidates for either a TB skin test (PPD) or Interferon Gamma Release Assay (IGRA), UNLESS a previous positive test has been documented.

Please answer the following Tuberculosis (TB) Screening Questions:

1.	Have you ever had a positive TB skin test?	❒ Yes	❒ No
2.	Have you ever had close contact with somebody ill with TB?	❒ Yes	❒ No
3.	Were you born in Africa, Eastern Europe, Asia, the Middle East , or South/Central America?	❒ Yes	❒ No
4.	Have you traveled to the areas listed above?	❒ Yes	❒ No
5.	Have you been vaccinated with BCG?	❒ Yes	❒ No
6.	Have you been an employee or volunteer in a prison, nursing home, homeless shelter, or hospital?	❒ Yes	❒ No

F. MENINGITIS VACCINE - STRONGLY RECOMMENDED FOR ALL NEW STUDENTS LIVING IN CAMPUS HOUSING

Strongly recommended for all new students living in campus housing ❒ Living Off Campus

College students, especially freshman living in residence halls, are at an increased risk for contracting meningococcal disease. The bacterial form of this disease can lead to serious complications such as swelling of the brain, coma, and even death within a short period of time. Immunization can prevent up to 80% of meningococcal meningitis in young adults. The vaccine is safe and effective against 4 of the 5 types of bacteria responsible for meningococcal meningitis in the United States and for the majority of the cases in the college age population. The Tennessee Department of Health **strongly urges** students to get the Meningitis Vaccine.

❒ I decline receipt of vaccine for meningococcal meningitis—attach a copy of waiver.
❒ I have received the meningococcal meningitis vaccine. Attach a copy of Immunization record showing Meningitis Vaccine.
❒ I plan to receive the meningococcal =meningitis vaccine.

Signature _____ **Date** _____

Return to: Enrollment Management, Welch College, 1045 Bison Trail, Gallatin, TN 37066
Contact information 615-675-5255, Fax 615-296-0400, email: recruit@fwbbc.edu

Medical Authorization Form

For All Students

DEAR PARENT/GUARDIAN/STUDENT:

This authorization form is now required of all students. Sometimes emergencies do arise, and we feel that you would want us to have your permission to authorize whatever kind of treatment or surgery a hospital/doctor deems necessary at that time.

Note to authorized legal guardians – If medical treatment requires consent, we will do our best to notify you by telephone. We will do for your daughter or son what we would do for one of our own children in the same circumstances.

Sincerely,
Jon Forlines
Dean of Students

*It is imperative that this document be notarized; that is, you must sign your signature in the presence of a notary public. Without this notarization your signature is not sufficient.

Student's Name (print) _____ Date of Birth _____

I authorize the Administration at Welch College to give permission to any hospital or physician to treat the student named above. This authorization covers medical transportation, the administration of anesthetics, surgery, or any other treatment a hospital/doctor deems essential at that time. In addition, it will remain in effect as long as the person named above lives in the dorm.

_____ Date _____

Student's Signature (only able to honor this signature if the student is at least 21 years of age at the date dorms are open, **or if the student is emancipated from parental guardianship**)

_____ Date _____

*Parent's Signature (required if the above does not apply)

(_____)_____

Cell Phone(s)

(_____)_____

Day Time Phone(s)

(_____)_____

Evening Phone(s)

_____

Notary Public

_____

My Term Expires

Return to Enrollment Management, Welch College, 1045 Bison Trail, Gallatin, TN 37066
Contact Information 615-675-5255, Fax 615-296-0400, email: recruit@welch.edu

MENINGOCOCCAL MENINGITIS
Waiver of Immunization

College students, especially freshman living in residence halls, are at an increased risk for contracting meningococcal disease. The bacterial form of this disease can lead to serious complications such as swelling of the brain, coma, and even death within a short period of time. Immunization can prevent up to 80% of meningococcal meningitis in young adults. The vaccine is safe and effective against 4 of the 5 types of bacteria responsible for meningococcal meningitis in the United States and for the majority of the cases in the college age population. Protection lasts approximately 8 years.

I have read the information provided about meningococcal disease, vaccine, and have made an informed decision to decline receipt of the vaccine. The Tennessee Department of Health **strongly urges** students to get the Meningitis Vaccine.

Signature _____ **Date** _____
Signature of student or parent/guardian (if student is under 18)

Return to: Enrollment Management, Welch College, 1045 Bison Trail, Gallatin, TN 37066
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Tuberculosis (TB) Risk Assessment

Student's Name _____ **Student's DOB** _____

Persons with any of the following risk factors are candidates for either a TB skin test (PPD) or Interferon Gamma Release Assay (IGRA), UNLESS a previous positive test has been documented.

Please answer the following additional TB risk screening questions:

1. **Does the student have HIV/AIDS?** ❒ Yes ❒ No
2. **Organ transplant recipient?** ❒ Yes ❒ No
3. **Immunosuppression (equiv to 15 mg prednisone or TNF-alfa antag)?** ❒ Yes ❒ No
4. **History of illicit drug use?** ❒ Yes ❒ No
5. **Chronic illness that may increase risk for TB progression (diabetes, silicosis, cancer, renal disease, malabsorption, or intestinal bypass)?** ❒ Yes ❒ No

Does the student have signs or symptoms of active TB?

If no, then proceed to #2, If YES, then proceed with further evaluation as indicated.

2. Medical assessment

a. Has +PPD been noted previously? ❒ Yes ❒ No

- *If yes, then chest x-ray is required within 6 months of entry:* *Date of CXR* ___/___/___ *Result* ❒ *Normal* ❒ *Abnormal*
- *If yes, has the patient completed a 9 mo course of INH?* ❒ Yes, completed ___/___/___ ❒ No

b. PPD (or IGRA) must be done if there is no history or previous positive PPD or IGRA. The PPD should be recorded as actual millimeters of induration and interpreted based on the guidelines (**) below.

Date read: ___/___/___ Result: _____mm of induration
**Interpretation (see guidelines below) ❒ Positive ❒ Negative

c. Interferon Gamma Release Assay (IGRA) - required only if PPD was not done

Date obtained: ___/___/___
Method: ❒ QFT-G ❒ QFT-GIT ❒ Other _____
Result: ❒ Positive ❒ Negative ❒ Intermediate
If the IGRA is POSITIVE, then chest x-ray is required within 6 months of entry: *Date of CXR* ___/___/___ *Result* ❒ *Normal* ❒ *Abnormal*

****Interpretation Guidelines**

>5 mm is positive:
- **Recent close contact with person with active TB**
- **Abnormal CXR c/w past TB disease**
- **Organ transplant or other immunosuppression**
- **HIV/AIDS**

>10 mm is positive:
- **Significant travel or residence in high prevalence area**
- **Illicit drug use**
- **Worker in healthcare, homeless shelter, prisons**
- **Chronic health issues, as per above screening questions**

>15 mm is positive if no risk factors

HEALTH CARE PROVIDER SIGNATURE REQUIRED:

Printed Name _____ **Address** _____

Signature _____ **Phone Number** _____ **Fax Number** _____

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