

# New England Conservatory Student Health Report

**Due Date:** June 1, 2011

**Mail to:** Health and Counseling Services  
290 Huntington Ave. SB 112  
Boston, MA 02115  
Phone: 617-585-1284  
Fax: 617-585-1208

All information disclosed on this form will be kept confidential and will not be released to anyone without your permission except as required by law.

**A penalty fee of \$100 will be assessed for an incomplete or late immunization record.**

**All required immunizations must be completed before the first day of classes.**

*PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.*

## General Information

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Female \_\_\_ Male \_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Place of birth \_\_\_\_\_ Citizenship \_\_\_\_\_ Mobile phone \_\_\_\_\_ Email address \_\_\_\_\_

Year enrolling \_\_\_\_\_ Undergrad \_\_\_ Grad \_\_\_ Major \_\_\_\_\_ Planning to live on campus? Yes \_\_\_ No \_\_\_

## Emergency Contact Information

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Country \_\_\_\_\_

Home phone \_\_\_\_\_ Mobile phone \_\_\_\_\_

## Consent for Treatment

I give the Health Center permission to provide me with medical and/or psychiatric care while enrolled as a student.

Full Name [please print] \_\_\_\_\_ [must be 18 or older] \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**If student is under 18 upon arrival at NEC, permission to treat must be signed by a parent or guardian.**

I give the Health Center permission to provide my daughter/son medical/psychiatric care while enrolled as a student.

Parent/Guardian Name [please print] \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

## Student Health Insurance

All full time students are **required by the state of Massachusetts to have U.S. based health insurance**. All full time NEC students are **automatically enrolled** in NEC's Student Health Insurance Plan. Information about the plan, with details about enrolling/waiving will be mailed in July with your NEC bill.

Health Services' use only

Date rec'd: \_\_\_\_\_

Complete \_\_\_\_\_

Missing \_\_\_\_\_ Date contacted: \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_

Name: \_\_\_\_\_

Date of birth (month/day/year): \_\_\_\_\_

**Mantoux tuberculin requirement -- student must complete all questions.**

1. Country of birth \_\_\_\_\_

2. To the best of your knowledge, have you had close contact with anyone who was sick with tuberculosis? \_\_\_ Yes \_\_\_ No

To answer the next two questions, please refer to the following list of countries and territories that have high rates of tuberculosis.

Afghanistan	Colombia	India	Moldova, Rep.	Senegal
Angola	Comoros	Indonesia	Mongolia	Sierra Leone
Armenia	Congo	Iran	Morocco	Solomon Islands
Azerbaijan	Congo, DR	Iraq	Mozambique	Somalia
Bahamas	Cote d'Ivoire	Kazakhstan	Myanmar	South Africa
Bahrain	Croatia	Kenya	Namibia	Sri Lanka
Bangladesh	Djibouti	Kiribati	Nepal	Sudan
Belarus	Dominican Rep.	Korea, DPR	New Caledonia	Suriname
Benin	Ecuador	Korea, Rep.	Nicaragua	Swaziland
Bhutan	El Salvador	Kyrgyzstan	Niger	Syrian Arab Rep.
Bolivia	Equatorial Guinea	Lao PDR	Nigeria	Tajikistan
Bosnia & Herzegovina	Eritrea	Latvia	Niue	Tanzania, UR
Botswana	Estonia	Lesotho	Northern Mariana Islands	Thailand
Brazil	Ethiopia	Liberia	Pakistan	Togo
Brunei Darussalam	Gabon	Lithuania	Palau	Tokelau
Burkina Faso	Gambia	Macedonia, TFYR	Panama	Turkmenistan
Burundi	Georgia	Madagascar	Papua New Guinea	Uganda
Cambodia	Ghana	Malawi	Paraguay	Ukraine
Cameroon	Guam	Malaysia	Peru	Uzbekistan
Cape Verde	Guatemala	Maldives	Philippines	Vanuatu
Central African Rep.	Guinea	Mali	Portugal	Vietnam
Chad	Guinea-Bissau	Marshall Islands	Romania	Yemen
China	Guyana	Mauritania	Russian Federation	Zambia
China, Hong Kong SAR	Haiti	Mauritius	Rwanda	Zimbabwe
China, Macao SAR	Honduras	Micronesia	Sao Tome & Principe	

3. Were you born in one of the countries on the list above? \_\_\_ Yes \_\_\_ No

4. Have you traveled or lived for more than one month in any of the countries on the list above? \_\_\_ Yes \_\_\_ No

If you answered yes to ANY of the questions above, you are required to submit documentation of a **Mantoux 5TU PPD** test (see below), or a QuantiFERON-TB Gold Assay test result. The test must have been performed within 6 months prior to arrival at NEC.

- Multiple-puncture TB test **are not acceptable** (Tine, Heaf, etc.).
- History of BCG vaccination is not a contraindication to TB testing.

**Testing documentation for a “yes” answer to any of the above questions:**

Mantoux PPD (tuberculin 5TU) test date \_\_\_\_\_ Results: size of induration \_\_\_\_\_ mm  
(Month/Day/Year) (Number in millimeters)

If a QuantiFERON-TB Gold assay was performed, **a copy of the test result must be submitted**. If the student had a positive Mantoux PPD or a positive QuantiFERON-TB Gold assay, did s/he receive prophylactic medication? \_\_\_ Yes \_\_\_ No

If yes, dates received: from \_\_\_\_\_ to \_\_\_\_\_  
(Month/Year) (Month/Year)

**If a student has had tuberculosis, OR has a positive reaction ( $\geq 10$ mm), OR has a known positive PPD, OR has a positive QuantiFERON-TB Gold assay, proof of a chest x-ray taken within 6 months prior to arrival at NEC is required. The report must be written in English and attached to this form.**

**Health Care Provider (MD/DO/NP/PA):**

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
Please print

Address or stamp \_\_\_\_\_ Phone \_\_\_\_\_

Name:

Date of birth (month/day/year):

### Immunization History

Massachusetts college immunization laws require documentation of the following, signed by a health care provider with month/day/year administered.

If on official letterhead you may attach a copy of high school, undergrad, or military records.

Lab reports of IgG antibody titres must be included to validate immunity to disease.

There is a fee for immunizations administered at the Health Center.

month/day/year

#### MMR (Measles, Mumps, Rubella)

##### 2 Doses Required

\_\_\_\_\_ Dose 1 (at 12 months of age or later, after 1968) Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ Dose 2 (at least 4 weeks after 1<sup>st</sup>) Date \_\_\_\_/\_\_\_\_/\_\_\_\_

- OR -

Measles (Rubeola) \_\_\_\_\_ Immune titer (attach lab report) Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Mumps \_\_\_\_\_ Immune titer (attach lab report) Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Rubella (German Measles) \_\_\_\_\_ Immune titer (attach lab report) Date \_\_\_\_/\_\_\_\_/\_\_\_\_

#### Diphtheria, Pertussis, Tetanus Booster (Tdap/Adacel, Boosterix, etc.)

\_\_\_\_\_ Tdap (within 10 years) Date \_\_\_\_/\_\_\_\_/\_\_\_\_

#### Meningococcal (MCV4 advised/Menactra, Meneveo, etc. or MPSV4/Menomune, etc.)\*

Name of vaccine: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

OR \_\_\_\_ Waiver form completed and attached Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\*All newly enrolled students living in residence on campus are required to receive the meningococcal vaccine prior to arrival on campus OR read, sign, and return the enclosed waiver.

#### Hepatitis B (Energix, Recombivax, Twinrix, etc.)

\_\_\_\_\_ Dose 1 (at any age) Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ Dose 2 (at least 4 weeks after 1<sup>st</sup>) Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ Dose 3 (6 months after 1<sup>st</sup>) Date \_\_\_\_/\_\_\_\_/\_\_\_\_

##### - OR - Recombivax HB

\_\_\_\_\_ Dose 1 (age 11 – 15 years) Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ Dose 2 (at least 4 months after 1<sup>st</sup>) Date \_\_\_\_/\_\_\_\_/\_\_\_\_

- OR -

\_\_\_\_\_ Immune titer (attach lab report) Date \_\_\_\_/\_\_\_\_/\_\_\_\_

#### Varicella (Chicken Pox)

\_\_\_\_\_ History of infection Date \_\_\_\_/\_\_\_\_/\_\_\_\_

- OR -

\_\_\_\_\_ Dose 1 Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ Dose 2 (at least 4 weeks after 1<sup>st</sup>) Date \_\_\_\_/\_\_\_\_/\_\_\_\_

- OR -

\_\_\_\_\_ Immune titer (attach lab report) Date \_\_\_\_/\_\_\_\_/\_\_\_\_

#### Health Care Provider (MD/DO/NP/PA):

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
Please print.

Address or stamp \_\_\_\_\_ Phone \_\_\_\_\_

Name:

Date of birth (month/day/year):

**Health Status**

This information, although not required, will help us meet your health care needs.  
You may attach a copy of your most recent physical.

To the examiner: Please comment on all pertinent findings.

List any significant past, or current, medical, surgical, or psychiatric conditions:

List all ongoing treatments/medications with dosages/necessary directions:

List any allergies to medicine/food/other:

Please check WNL or note findings:

Mental Health:	WNL ___ Other: _____	Abdomen:	WNL ___ Other: _____
HEENT:	WNL ___ Other: _____	Genitalia:	WNL ___ Other: _____
Neck/Thyroid:	WNL ___ Other: _____	Musculoskeletal:	WNL ___ Other: _____
Heart :	WNL ___ Other: _____	Neurological:	WNL ___ Other: _____
Lungs:	WNL ___ Other: _____	Extremities:	WNL ___ Other: _____
Breasts:	WNL ___ Other: _____	Skin:	WNL ___ Other: _____

Health Care Provider (MD/DO/NP/PA):

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
Please print

Address or stamp \_\_\_\_\_ Phone \_\_\_\_\_