

New England Conservatory Student Health Report

Due Date: June 1, 2010

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.

Please note one of the following: _____ I will **ENROLL** in NEC's Student Health Insurance Plan.

_____ I will **WAIVE** NEC's Student Health Insurance Plan.

.....
Health Services' use only

Date rec'd: _____

Complete _____

Missing _____ Date contacted: _____ Phone _____ Email _____

Name:

Date of birth (m/d/y):

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 (≥ 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 (m/d/y): _____

Immunization History

Massachusetts college immunization laws require documentation of the following, indicating month/day/year administered and signed by a health care provider. You may attach a copy of high school, undergrad, or military records on official letterhead. Since the Hepatitis B series is over several months, you must have at least one injection prior to registration. A fee will be incurred 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 apart).....Date _____/_____/_____

- OR -

IgG antibody titres indicating immunity to illness – must attach lab report:

Measles (Rubeola) _____ Immune titer (w/lab report) Date _____/_____/_____

Mumps _____ Immune titer (w/lab report) Date _____/_____/_____

German Measles (Rubella) _____ Immune titer (w/lab report) Date _____/_____/_____

Tetanus/Diphtheria or Tdap

_____ Td*.....Date _____/_____/_____

- OR -

_____ Tdap (recommended)Date _____/_____/_____

*Booster required within 10 years of registration.

Meningococcal*

_____ Menactra/MCV4 (after 1/1/05).....Date _____/_____/_____

- OR -

_____ Menomune (after 9/1/05)Date _____/_____/_____

- OR -

_____ Waiver form completed and attached.....Date _____/_____/_____

*All newly enrolled graduate or undergraduate 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

_____ Series of 3..... Dose 1.....Date _____/_____/_____

Dose 2*.....Date _____/_____/_____

Dose 3*.....Date _____/_____/_____

- OR -

_____ Other (with names and dates of combination vaccine or 2 dose schedule)

- OR -

_____ Immune titer (attach lab report)..... Date _____/_____/_____

*The 2nd at least 4 weeks after the 1st, the 3rd at least 4 months after the 1st.

Varicella (Chicken Pox)

_____ History of infection..... Date _____/_____/_____

- OR -

_____ Dose 1 VaricellaDate _____/_____/_____

_____ Dose 2 Varicella Vaccine*.....Date _____/_____/_____

- OR -

_____ Immune titer (attach lab report) Date _____/_____/_____

- OR -

_____ Has not been vaccinated, no history of disease.

*At least 4 weeks after the 1st dose.

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

Name _____ Signature _____ Date _____
Please print.

Address or stamp _____ Phone _____

Name:

Date of birth (m/d/y):

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 _____