New England Conservatory Student Health Report

Due Date: January 7, 2019

Mail to: New England Conservatory
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 $150 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

_____ Female____Male____Other___ Date of Birth_____/_____/_____
Name: Last First Middle Month Day Year

_____ _____ _____ _____
Place of birth Citizenship Mobile phone Email address

Year enrolling _____ Undergrad____Grad _____ Major _____ Planning to live in the SLPC (on campus)? Yes_____No_____

Emergency Contact Information

_____
Name Relationship

_____
Address: Street City State/Province Zip/Country

_____ _____ _____
Home phone Mobile phone Email address

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 and/or psychiatric care while enrolled.

_____
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 attach a copy of your health insurance card (front & back) to your Student Health Report.**

Name: **Date of birth (month/day/year):**

Immunization History

Massachusetts college immunization laws require documentation of the following vaccines signed by a health care provider with month/day/year administered. You may attach a copy of high school, undergrad, or military records IF on official letterhead. A copy of lab reports of IgG antibody titers **must be included to validate immunity to disease.**

A. MMR (MEASLES, MUMPS, RUBELLA)

1. Dose 1 given at age 12 months or later. .....#1 ____/____/_____ (M D Y)
2. Dose 2 given at least 28 days after first dose. .....#2 ____/____/_____ (M D Y)

B. DIPHTHERIA, TETANUS, ACELLULAR PERTUSSIS (DTap) Booster must be within 10 years

1. Childhood series completed? Yes ___ No ___ Date of last dose in series: ____/____/_____ (M D Y)
2. Date of most recent booster dose: ____/____/_____ (M D Y) Type of booster: Td _____ Tdap _____

C. MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135)*formally MCV4

1. Quadrivalent conjugate (preferred)

   a. Dose #1 ____/____/_____ (M D Y) **OR**

   b. Waiver form completed and attached Date ____/____/_____ (M D Y)

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

D. HEPATITIS B

1. Immunization (Hepatitis B)

   a. Dose #1 ____/____/_____ (M D Y) Adult formulation ____ Child formulation ____

   b. Dose #2 ____/____/_____ (M D Y) Adult formulation ____ Child formulation ____

   c. Dose #3 ____/____/_____ (M D Y) Adult formulation ____ Child formulation ____

2. Immunization (Combined hepatitis A and B vaccine)

   a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y) c. Dose #3 ____/____/_____ (M D Y)

OR PROOF OF IMMUNITY

3. Hepatitis B surface antibody (HsAb) (**Please attach copy of lab report**)

   Date ____/____/_____ Result: Reactive _____ Non-reactive _____

E. VARICELLA

1. Immunization

   a. Dose #1 given at age 12 months or later. .....#1 ____/____/_____ (M D Y)

   b. Dose #2 given at least 12 weeks after first dose ages 1–12 years. .....#2 ____/____/_____ (M D Y)
   and at least 4 weeks after first dose if age 13 years or older.

2. History of Disease Yes _____ ____/____/_____ (M D Y) No _____ or Birth in U.S. before 1980 Yes ___ No ___

OR PROOF OF IMMUNITY

3. Varicella IgG Ab (**Please attach copy of lab report**)

   Date ____/____/_____ Result: Positive _____ Negative _____

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

Name_____ (Please print.) Signature_____ Date _____

Address or stamp_____ Phone _____ Fax _____

Name: **Date of birth (month/day/year):**

Health Status

This information will be kept confidential and will help us to meet your health care needs while you are studying at NEC.

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 (within normal limits) 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: _____

Name: **Date of birth (month/day/year):**

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

Name_____ Signature_____ Date _____
Please print

Address or stamp_____ Phone _____ Fax_____