New England Conservatory Student Health Report

Due Date: January 15, 2021

Mail to: New England Conservatory
Health and Counseling Center
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

Name: Last First Middle Preferred Name:

Date of Birth: _____/_____/_____ Month Day Year

What is your gender ? □ Man □ Woman □ Non-binary □ Other gender not listed here:_____ Do you identify as transgender? □ Yes □ No

What are your pronouns? □ He/Him/His □ She/Her/Hers □ They/Them/Theirs □ Other pronouns not listed here: _____

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 & Counseling 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.**

REQUIRED IMMUNIZATIONS:

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 (Tdap) 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: ____/____/_____ Type of booster: Td _____ Tdap _____
   M D Y

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

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).

   a. Dose #1 ____/____/_____ **OR** b. **Waiver form** completed and attached Date ____/____/_____
   M D Y M D Y

***1 dose MenACWY (formerly MCV4) is required for all full-time students 21 years of age or younger. The dose of MenACWY vaccine must have been received on or after the student's 16th birthday. Doses received at a younger ages do not count towards this requirement. Students may decline MenACWY vaccine after they have read and signed the MDPH Meningococcal Information and Waiver Form.**

Meningococcal B vaccine is not required (BUT recommended) and does not meet this requirement.

HEPATITIS B

1. Immunization (hepatitis B)

   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____
   M D Y M D Y M D Y
   Adult formulation ____ Child formulation ____ Adult formulation ____ Child formulation ____ Adult formulation ____ Child formulation ____

2. Immunization (Combined hepatitis A and B vaccine)

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

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

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

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_____ Signature_____ Date _____
Please print.

Address or stamp_____ Phone _____ Fax _____

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

REQUIRED IMMUNIZATIONS

2020-2021 Seasonal Influenza

1. Immunization

   a. Vaccine name (Afluria, Flucelvax, Fluzone, etc) ._____/_____/ .....
   M D Y

RECOMMENDED IMMUNIZATIONS

MENINGOCOCCAL SEROGROUP B (MenB) Bexsero OR Trumenba

1. Immunization (Bexsero -2 doses 1 month apart)

   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____
   M D Y M D Y

   or

2. Immunization (Trumenba- 2 doses 6 months apart)

   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____
   M D Y M D Y

HUMAN PAPILLOMA VIRUS (HPV) (*With the exception of immunocompromised persons, or persons with auto-immune disease, a 2-dose schedule may be followed for all persons initiating the HPV vaccine series before age 15yrs, otherwise 3 doses required.)*

1.Immunization (Gardasil Quadrivalent)

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

2.Immunization (Gardasil -9 valent)

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

HEPATITIS A (Hep A)

   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____
   M D Y M D Y

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

Name_____ Signature_____ Date _____
Please print.

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 finding)*

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: _____

NEC Health Center TB Screening Form

Name: _____ Date of Birth: _____/_____/_____
Month/Day/Year

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

Name_____ Signature_____ Date _____
Please print

Address or stamp_____ Phone _____ Fax_____

Part I: Tuberculosis (TB) Screening Questionnaire (*to be completed by ALL incoming students*)

**** The significance of the travel exposure should be discussed with a health care provider and evaluated.***

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? ❑ Yes ❑ No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below) ❑ Yes ❑ No

Afghanistan	Comoros	Iraq	Namibia	Somalia
Algeria	Congo	Kazakhstan	Nauru	South Africa
Angola	Côte d'Ivoire	Kenya	Nepal	South Sudan
Anguilla	Democratic People's Republic of Korea	Kiribati	New Caledonia	Sri Lanka
Argentina		Kuwait	Nicaragua	Sudan
Armenia	Democratic Republic of the Congo	Kyrgyzstan	Niger	Suriname
Azerbaijan		Lao People's Democratic Republic	Nigeria	Swaziland
Bangladesh	Djibouti		Northern Mariana Islands	Syrian Arab Republic
Belarus	Dominican Republic	Latvia		Taiwan
Belize	Ecuador	Lesotho	Pakistan	Tajikistan
Benin	El Salvador	Liberia	Palau	Tanzania (United Republic of)
Bhutan	Equatorial Guinea	Libya	Panama	Thailand
Bolivia (Plurinational State of)	Eritrea	Lithuania	Papua New Guinea	Timor-Leste
Bosnia and Herzegovina	Ethiopia	Madagascar	Paraguay	Togo
Botswana	Fiji	Malawi	Peru	Tunisia
Brazil	Gabon	Malaysia	Philippines	Turkmenistan
Brunei Darussalam	Gambia	Maldives	Portugal	Tuvalu
Bulgaria	Georgia	Mali	Qatar	Uganda
Burkina Faso	Ghana	Marshall Islands	Republic of Korea	Ukraine
Burundi	Greenland	Mauritania	Republic of Moldova	Uruguay
Cabo Verde	Guam	Mauritius	Romania	Uzbekistan
Cambodia	Guatemala	Mexico	Russian Federation	Vanuatu
Cameroon	Guinea	Micronesia (Federated States of)	Rwanda	Venezuela (Bolivarian Republic of)
Central African Republic	Guinea-Bissau		Sao Tome and Principe	
Chad	Guyana	Mongolia	Senegal	Viet Nam
China	Haiti	Montenegro	Serbia	Yemen
China, Hong Kong SAR	Honduras	Morocco	Sierra Leone	Zambia
China, Macao SAR	India	Mozambique	Singapore	Zimbabwe
Colombia	Indonesia	Myanmar	Solomon Islands	

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rates of ≥ 20 cases per 100,000 population.

Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CHECK the countries or territories, above) ❑ Yes ❑ No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ❑ Yes ❑ No

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? ❑ Yes ❑ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? ❑ Yes ❑ No

If the answer is YES to any of the above questions, the New England Conservatory of Music Health Center requires that you receive TB testing as soon as possible and no more than 6 months prior to the start of the subsequent semester. **See Part II. If the answer to all of the above questions is NO**, no further testing or further action is required.

NEC Health Center TB Screening Form

Name: _____ Date of Birth: _____/_____/_____

Month/Day/Year

Part II. Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in Part I. **Persons answering YES to any of the questions in Part I are required to have an Interferon Gamma Release Assay (IGRA) blood test**, unless a previous positive blood test has been documented. Examples of acceptable IGRA blood tests include:

- T-Spot®
- TB QuantiFERON®-TB Gold (QFT-G)
- QuantiFERON®-TB Gold Plus (QFT-Plus)
- QuantiFERON®-TB Gold In-Tube (QFT-GIT)

History of a positive TB skin test or IGRA blood test? (If yes, document below) **Yes _____ No _____**

History of BCG vaccination? **Yes_____ No _____**

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1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes_____No _____

If YES, check below:

- ☐ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- ☐ Coughing up blood (hemoptysis)
- ☐ Chest pain
- ☐ Loss of appetite
- ☐ Unexplained weight loss
- ☐ Night sweats
- ☐ Fever

Proceed with additional evaluation to exclude active tuberculosis disease including, chest x-ray, and sputum evaluation as indicated.

If NO, proceed to IGRA testing below:

2. Interferon Gamma Release Assay (IGRA) ***(Attach lab report)***

Date Obtained:_____/____/____ (Specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative_____ positive____ indeterminate_____ borderline_____(T-Spot only)

3. Chest x-ray*: (Required if IGRA is positive)

Date of chest x-ray:_____/____/____ Result: normal_____abnormal_____
M D Y

*****If the student has a positive IGRA test, 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.**

NEC Health Center TB Testing Form

(MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER)

Name: _____ Date of Birth: _____/_____/_____

Month/Day/Year

Part III. Management of Positive IGRA

All students with a positive IGRA blood test with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- ❑ Infected with HIV
- ❑ Recently infected with *M. tuberculosis* (within the past 2 years)
- ❑ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- ❑ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- ❑ Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- ❑ Have had a gastrectomy or jejunoileal bypass
- ❑ Weigh less than 90% of their ideal body weight
- ❑ Cigarette smokers and persons who abuse drugs and/or alcohol
- ❑ Other

_____Student **AGREES** to receive treatment*

_____Student **DECLINES** treatment at this time

* Please indicate the prescribed treatment regimen if the patient was treated for Latent Tuberculosis by listing the list the medication name (s), dosage, and duration of therapy:

Medication Name	Dosage	Frequency of Medication	Duration of Treatment

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

Name_____ Signature_____ Date _____/_____/_____

(Print) (Sign)

Address:_____ Phone _____

(May use office stamp)

Form adapted from ACHA Guidelines: Tuberculosis Screening and Targeted Testing of College and University Students. Retrieved from http://www.acha.org/documents/resources/guidelines/ACHA_Tuberculosis_Screening_2017.pdf