

New England Conservatory New Student Health Report

Fall 2026

Due Date: July 18, 2026

Upload to: [NEC Student Health Portal](#)

If Unable to Upload, Mail to:

All required immunizations must be completed before the first day of classes. Students who do not submit documentation will have a compliance "hold" placed on their account that prevents them from registering for classes. All information disclosed on this form will be kept confidential and will not be released without your permission except as required by law.

Counseling & Wellness Center
New England Conservatory
290 Huntington Ave. SB 112
Boston, MA 02115
Phone: 617-585-1284
Fax: 617-585-1208

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORD

General Information

Name

Date of Birth

____/____/____
M D Y

Last

First

Middle

Preferred Name: _____

What is your gender? Man Woman Non-binary Other gender not listed here: _____

Do you identify as transgender? Yes No Prefer not to say

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

Emergency Contact Information

Full Name

Relationship

Home Phone

Mobile Phone

Email Address

Address: _____

Street

City

State/Province

Zip/Country

Consent for Treatment

I give NEC 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 NEC 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 be enrolled in a comprehensive health insurance plan. Students will be **automatically enrolled** in NEC's Student Health Insurance Plan unless the plan is waived by August 29, 2026.

To be eligible to waive your student health insurance plan, you must be enrolled in a health insurance plan that meets Massachusetts mandatory requirements. To find out if you qualify to waive your insurance, visit gallagherstudent.com/nec and review the FAQ document.

For more information on enrolling/waiving your student health insurance visit necmusic.edu/business-office/student-billing/. Information about the plan, with details about enrolling/waiving, will also be mailed in July with your NEC bill.

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. Please see below for the required, recommended, and optional vaccinations.

Required Vaccinations	Requirements	Dates Given
Hepatitis B	3 doses of Hepatitis B vaccine OR 3 doses of Hep A & B Combined OR 2 doses of Heplisav after age 18 OR Positive Titer	<p>____/____/____, ____/____/____, ____/____/____ M D Y M D Y M D Y</p> <p>____/____/____, ____/____/____, ____/____/____ M D Y M D Y M D Y</p> <p>____/____/____, ____/____/____ M D Y M D Y</p> <p>____/____/____ M D Y</p>
Meningococcal Quadrivalent ONLY newly enrolled full-time students 21 years of age and under	1 dose given at age 16 or older OR Signed MDPH Waiver	<p>____/____/____ M D Y</p> <p>Please attach completed waiver.</p>
MMR (Measles, Mumps, Rubella)	2 doses given after 1st birthday (Minimum of 24 days apart) OR Individual Titers (Positive)	<p>____/____/____, ____/____/____ M D Y M D Y</p> <p>Measles Mumps Rubella</p> <p>____/____/____, ____/____/____, ____/____/____ M D Y M D Y M D Y</p>
Tdap (Tetanus, Diphtheria, Pertussis)	Tdap one dose age 10 or older	<p>____/____/____ M D Y</p>
Varicella	2 doses given after 1st birthday (Minimum of 24 days apart) OR Positive Titer OR History of Disease	<p>____/____/____, ____/____/____ M D Y M D Y</p> <p>____/____/____ M D Y</p> <p>____/____/____ M D Y</p>

Recommended Vaccinations	Specifications	Dates Given
COVID- 19	Most recent COVID booster	<p>____/____/____ M D Y</p>
In(flu)enza		<p>____/____/____ M D Y</p>

Optional Vaccinations	Specifications	Dates Given
Hepatitis A		/ / / , / / / M D Y M D Y
HPV (Human Papillomavirus)		/ / / , / / / , / / / M D Y M D Y M D Y
Meningococcal Group B	Bexsero OR Trumenba	/ / / , / / / M D Y M D Y / / / , / / / , / / / M D Y M D Y M D Y
Td (Tetanus)	Booster is recommended if last dose of Tdap is greater than 10 years.	/ / / M D Y

If there is a medical or religious exemption to any immunization, please complete [Vaccination Declination Form](#). Other notes may be listed below:

Health Care Provider

Name (Print): _____ Signature: _____ Date: _____

Address: _____ Phone: _____ Fax: _____

Tuberculosis (TB) - Screening Questionnaire:

1. Have you ever had close contact with persons known or suspected to have active TB disease? Yes _____ No _____
2. 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 or territory below.) Yes _____ No _____
3. 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, please star the countries or territories below.) Yes _____ No _____

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

4. Have you been a resident, volunteer, and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? Yes _____ No _____
5. Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? Yes _____ No _____
6. Have you ever been a member of any of the following groups that may have an increased incidence of latent Tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? Yes _____ No _____

<p>If the answer is YES to <u>any</u> of the previous questions, please see the following pages for further evaluation.</p>	<p>If the answer is NO to <u>all</u> of the previous questions, no further assessment is required at this time.</p>
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Tuberculosis (TB) - Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in the TB Screening Questionnaire. **Persons answering YES to any of the questions above 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)

Patient History

Patient history of a positive TB skin test or IGRA blood test? (If yes, please list below.) Yes _____ No _____

Type of Test	Date
_____	_____ M D Y

Patient history of receiving the BCG vaccination? (If yes, please list below.) Yes _____ No _____

Date
_____ M D Y

Tuberculosis Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes _____ No _____

If **YES**, please proceed with additional evaluation to exclude active tuberculosis disease including, chest x-ray, and sputum evaluation as indicated. Please also indicate the symptoms 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

If **NO**, proceed to IGRA testing below:

Interferon Gamma Release Assay (IGRA) - Lab report must be attached.

Method: (Please circle one)	Result: (Please circle one)	Date Resulted:
QFT-GIT T-Spot Other (Write below) _____	Positive Negative Indeterminate Borderline (T-Spot Only)	_____ M D Y

