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**Due Date: December 15, 2023****Upload to:** <https://necmusic.edu/student-health-portal>**If Unable to Upload, Mail to:**

Counseling and Wellness Center  
New England Conservatory  
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 Date of Birth: Month / Day / Year  
Preferred Name:

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 \_\_\_\_\_  
Undergrad \_\_\_\_\_ Grad \_\_\_\_\_ Major \_\_\_\_\_ Planning to live in the SLPC (on campus)?  
Year enrolling \_\_\_\_\_ Yes \_\_\_\_\_  
No \_\_\_\_\_

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**Emergency Contact Information**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address: Street \_\_\_\_\_ City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Country \_\_\_\_\_  
Home phone \_\_\_\_\_ Mobile phone \_\_\_\_\_ Email address \_\_\_\_\_

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**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 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.

**Name:**

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

## 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.

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

### 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\*:      /      /       
M D Y

Type of booster: Td      Tdap     

\* Must be within 10 years

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

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

a. Dose #1      /      /       
M D Y

OR b. Waiver form completed and attached Date      /      /       
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.

#### D. HEPATITIS B

1. Immunization (Hepatitis B)

a. Dose #1      /      /       
M D Y

b. Dose #2      /      /       
M D Y

c. Dose #3      /      /       
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      /      /       
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     

#1      /      /       
M D Y

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

#2      /      /       
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 \_\_\_\_\_

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**REQUIRED 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 PAPILLOMAVIRUS (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 -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 \_\_\_\_\_

## 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:

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

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List any allergies to medicine/food/other:

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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: \_\_\_\_\_

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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 incoming students)*

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2018. Countries with incidence rates of  $\geq 20$  cases per 100,000 population. For future updates, refer to <http://www.who.int/tb/country/en/>.

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)

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

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 ☐ Yes ☐ No

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 Service requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester).

**If the answer to all the above questions is NO**, no further testing or further action is required.

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

## **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) (***LAB REPORT MUST BE ATTACHED***)**

## NEC TB Screening/Testing Form

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

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Date Obtained: \_\_\_\_/\_\_\_\_/\_\_\_\_ (Specify method) **Month/Day/Year**  
M D Y QFT-GIT T-Spot other\_\_\_\_

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.**

### 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 jejunioileal bypass
- ☐ Weigh less than 90% of their ideal body weight
- ☐ Cigarette smokers and persons who abuse drugs and/or alcohol
- ☐ Other



**NEC TB Testing Form**  
(MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER)

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

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ 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 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 \_\_\_\_\_ (Print) Signature \_\_\_\_\_ (Sign) Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Phone \_\_\_\_\_  
(May use office stamp)

*Form adapted from ACHA Guidelines: Tuberculosis Screening and Targeted Testing of  
College and University Students. Retrieved from*