

New England Conservatory Student Health Report

Mail to: New England Conservatory, Office of Admissions
290 Huntington Avenue, Boston, MA 02115

Due Date: July 1, 2008

Late Fee: \$100

Student ID _____	NEC USE ONLY
BIDMC _____	
Admissions Date Received	

General Information

All information disclosed on this form will be kept confidential and will be shared with appropriate personnel on a need-to-know basis only. Please return your completed report to Admissions by **July 1st**. ALL sections must be completed. **Incomplete or late Health Reports will be assessed a \$100 fee.** You are encouraged to keep a copy of this form for your records.

Last Name _____			First Name _____			Middle Initial _____			Birth Date _____/_____/_____						
									Month / Day / Year						
Home/Permanent Address/ Street/Apt. _____				City _____				State / Province _____				ZipCode _____		Country _____	
Home/Perm. Phone Number _____			Mobile Phone Number _____			Gender _____			Soc. Sec. Number _____						
Will you live on-campus Fall 08?		YES		NO		<i>If NO, please provide your local contact information below</i>									

Campus/Local address will be used for communications from NEC Health Center and the Beth Israel Deaconess Medical Center. If you do not have a local address yet, leave blank, you will be required to provide your local address during orientation.

Local Address (Street/Apt. #) _____			City _____			State _____			Zip _____			Local phone number _____		
Place of Birth _____						Citizenship _____								
Year at NEC [freshman, sophomore, etc] _____						Expected Year of Graduation _____								

Emergency Contact Information

Name _____			Relationship _____								
Address Street _____			City _____			State / Province _____			Zip / Country _____		
Phone Home _____			Phone Office _____			Phone Cell _____					

Health Center / Health Insurance Coverage

Health Center: All incoming students are automatically enrolled in the NEC Health Center. Our Health Center is located on the first floor of St. Botolph. We offer Primary & Episodic Care as well as any necessary referrals with out any additional out of pocket expenses.

Health Insurance: It is a Massachusetts law that all students must carry comprehensive U.S. based student health insurance.

All international students at NEC are **REQUIRED** to participate in the NEC provided Student Health Insurance Plan, and will be automatically enrolled.

Will you / are you required to participate in the Student Health Insurance Plan, provided througuh NEC? _____ YES _____ NO
If NO, you must provide your U.S. based health coverage information below

Health Insurance Company _____		Policy Number _____		Group Number _____		Policy Holder _____	
Insurance Claim Address _____				Insurance Phone Number [1.800 #] _____		Effective Dates _____	

Consent for Treatment for Students under age 18 - To be signed by parent or guardian if student is under 18 upon arrival at NEC.

I give permission for medical treatment for my dependent if an accident or illness should occur while a student at NEC. This includes referral to a local hospital, hospitalization, anesthesia, and/or surgery should it be necessary and I am unable to be reached.

Parent/Guardian Name [please print]

Date

Signature

Date

.....NEC USE ONLY BELOW LINE

NEC Health Center Review Date: _____ Reviewed By: _____

_____ No Action Necessary

_____ Action Taken: _____

Immunization History (Required. Must be completed by physician, ARNP, PA)

Immunization history and compliance with immunization law is required of all students by the Commonwealth of Massachusetts. Noncompliance could result in dismissal from NEC.

TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER, dates must be provided.

MMR (Measles, Mumps, Rubella) *
2 DOSES REQUIRED

_____ Dose 1 – immunized after age 12 months Date ____/____/____
_____ Dose 2 – immunized at age 5 years or later Date ____/____/____

* Month, day and year administered is required. Since 1968, must be at least 30 days apart

- OR -

POSITIVE TITRES to all of the below indicating previous infection and/or immunity to these illnesses.

MEASLES (Rubeola) Titre _____ Result of titre (positive/immune or negative) Date ____/____/____

MUMPS Titre _____ Result of titre (positive/immune or negative) Date ____/____/____

GERMAN MEASLES (Rubella) Titre _____ Result of titre (positive/immune or negative) Date ____/____/____

Required.

DIPHTHERIA / TETANUS or TDAP _____ Completed series (DPT) Date ____/____/____
_____ Received TD booster **within 10 years** Date ____/____/____

Required within 10 years of registration. May substitute one dose of Tdap.

MENINGOCOCCAL _____ Vaccination against bacterial meningitis Date ____/____/____
_____ Waiver form completed and attached Date ____/____/____

Required: Massachusetts requires all new students to receive the meningococcal vaccine prior to the beginning of classes. Students may complete and return the waiver form if they do not wish to receive the vaccine. **See waiver at the end of this form.**

HEPATITIS B _____ Completed series Dose 1 Date ____/____/____
Dose 2 Date ____/____/____
- OR - Dose 3 Date ____/____/____
_____ Positive immune titer Date ____/____/____

Required series of 3: The 2nd at least 30 days after the 1st, the 3rd at least 5 months after the 2nd.
All Incoming students must have Dose 1 when turning in this form and have received dose 2 before registration.

Varicella/Chicken Pox _____ Had Chicken Pox Virus Date ____/____/____
_____ Completed vaccination Date ____/____/____
_____ Has not had Virus, Has not been vaccinated. Date ____/____/____

NOT required by law: for the safety of our students we like to know their immune status.

PPD / MANTOUX TEST

Please answer the questions below:

1 – Have you had close contact with anyone sick with tuberculosis [TB]? _____ Yes _____ No

2 – Were you born in a county **NOT** listed below? _____ Yes _____ No Country of Birth _____

European Region: Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom

Western Pacific Region: America Samoa, Australia, New Zealand

American Region: Canada, Jamaica, St. Kitts & Nevis [USA], St. Lucia [USA], Virgin Islands [USA], USA

If you answered Yes to any of the above questions, you are required to have a tuberculin skin test to check for latent tuberculosis infection. Please note any treatment and/or follow up required.

_____ Received PPD (Mantoux) test 6 months prior to registration
Result: mm _____ Induration Date ____/____/____

Required if answer yes to either question above.

HEALTH CARE PROVIDER (MD, ARNP, or PA).

NAME, MD/ARNP/PA _____
Please print clearly

DATE _____

ADDRESS _____

TEL. _____

SIGNATURE _____

FAX _____

Health Statement (Not Required but Recommended: This will help our Health Center Staff know your health care needs)

TO THE EXAMINER: Please complete the PHYSICAL EXAMINATION below. Please comment on all pertinent findings and be sure all information is complete. Also, include a summary of the student's pertinent conditions/treatments and medications.

NAME _____ GENDER _____ DATE OF BIRTH ____/____/____
M D Y

History

List all significant past, or current, medical, surgical, or psychiatric conditions:

List all ongoing treatments/medications with dosages/direction:

Allergies to Medicine/Food/Other?

Exam "WNL" – or note abnormalities

MENTAL/EMOTIONAL STATUS:

HEART:

SKIN:

ABDOMEN:

HEENT:

EXTREMITIES:

NECK, THYROID:

NEUROLOGICAL:

LUNGS:

GENITALS/HERNIA:

List all pertinent physical exam findings:

HEALTH CARE PROVIDER (MD, ARNP, or PA).

NAME, MD/ARNP/PA _____
Please print clearly

DATE _____

ADDRESS _____

TEL. _____

SIGNATURE _____

FAX _____