Juilliard Health Record Form Fall 2024

The Juilliard School
Health and Counseling Services
60 Lincoln Center Plaza
New York, NY 10023
Phone: 212-799-5000 Ext 282
Fax: 212-496-4927
Email: healthservices@juilliard.edu
https://www.juilliard.edu/campus-life/well-being/health-and-counseling-services

Welcome to Juilliard. We look forward to meeting you and providing you with high-quality health care while you are a student. In order to accomplish this, we must have a comprehensive health history, including a record of all immunizations (or documentation of serological immunity) and the completed Tuberculosis Screening Form.

If you have any questions or need assistance with this form, please feel free to reach out to us at healthservices@juilliard.edu or 212-799-5000 ext. 282.

Student Health Record Checklist – **Due July 15, 2024**

- All documents must be in English.
- Fill out pages 1-4, you must sign pages 3 & 4 (if you are under 18, a parent or guardian must sign.)
- Fill out page 5, TB Screening form. If the answer is "yes" to any of the questions, the Tuberculosis Risk Assessment, page 6, must be completed and signed by a healthcare provider and the TB testing must be performed within 12 months prior to arrival at School.
- Immunization Record, pages 7-8. This form must be filled out by a medical provider or you may use official documentation signed by an MD, DO, PA or NP instead of this form.
- Attach any documents requested.
- Keep a copy of these documents for your records.

Choose one of the following methods to submit the Health Record Form:

- Preferred: Upload this document through the secure Medicat Portal in OKTA or www.juilliard.edu/studenthealth (you should receive access to Medicat in OKTA in June)
- Email to healthservices@juilliard.edu or
- Mail to: Juilliard Health Services
  60 Lincoln Center Plaza
  New York, NY 10023

PLEASE SEE COLLEGE STUDENT IMMUNIZATION POLICY FOR MORE DETAILS:
https://www.juilliard.edu/school/about/policies-consumer-information

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STUDENT DEMOGRAPHICS			
Last Name:	First Name:	Middle Name:	Pronouns:
What name would you like us to use:			
Birth Date (month/day/year):	Gender:	Juilliard Division:	If Music, instrument:
Are you a Juilliard Graduate:	If yes, when did you graduate:	Will you live in the Juilliard Residence Hall?	
Permanent Address:			
City/State/Zip/Country:			
Home Phone:	Cell Phone:	Email:	
Name of Parent, Guardian or Spouse/Partner:			
Address:			
City/State/Zip/Country:			
Home Phone:	Cell Phone:	Email:	

FAMILY HISTORY- Check each item							
Condition	No	Yes	Who and what?	Condition	No	Yes	Who and what?
Alcohol or drug problems/abuse	☐	☐		High Blood Pressure	☐	☐	
Asthma	☐	☐		Kidney Disease	☐	☐	
Cancer, leukemia or lymphoma	☐	☐		Migraine	☐	☐	
High Cholesterol	☐	☐		Stroke	☐	☐	
Diabetes Mellitus	☐	☐		Sudden death under age 50	☐	☐	
Emotional/ Psychological problems	☐	☐		Tuberculosis	☐	☐	
Heart attack, disease, or problem	☐	☐		Other-please specify	☐	☐	

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PERSONAL HEALTH HISTORY
Student Name:
1 Do you have allergies/adverse reactions to medications/food/insects/other? ☐ No ☐ Yes If yes, please list and note severity:
2 Do you take any medications on a frequent or regular basis? ☐ No ☐ Yes
Please list ALL prescriptions AND nonprescription medications AND supplements:
3 If you have a cervix, please answer the following:
Do you get your period monthly? ☐ No ☐ Yes
If you are 21 or over, date of last Pap test
4 Have you had any surgeries or operations (including appendectomy, splenectomy, tonsillectomy, etc.)? ☐ No ☐ Yes If Yes, include the type and date.
5 Please list below any medical and mental health conditions for which you have been treated (include the year(s)).
If you are student who experiences or has experienced learning difficulties or a physical or mental impairment that substantially limits one or more major life activities and you are interested in any supports available at Juilliard, please contact the Office of Academic Support and Disability Services at OASDS@juilliard.edu .

MENINGOCOCCAL MENINGITIS FORM - Please check one of the boxes and sign	
Student Name:	
I have (for students under the age of 18: My child has):	
☐	had meningococcal immunization ACWY within the past 5 years. The vaccine record is attached. [Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment, preferably on or after their 16th birthday, and that young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series. College and university students should discuss the Meningococcal B vaccine with a healthcare provider.]
☐	Read, or have had explained to me, the information regarding meningococcal disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal disease.
Signature: Student/ Parent or Guardian Signature if student is under 18 years.)	Date:

Please Note: The Juilliard School requires that students living on-campus in the Residence Hall receive one dose of Meningococcal Meningitis vaccine ACWY at age 16 or older.

For more information about Meningococcal Disease and vaccination please consult your medical provider or see the links below:

Meningococcal Disease NYSDOH: https://www.health.ny.gov/publications/2168/
Learn more about meningococcal disease: www.cdc.gov/meningococcal/
Meningococcal Disease and vaccination: https://www.cdc.gov/vaccines/vpd/mening/index.html
For more information about vaccine-preventable diseases: www.health.ny.gov/prevention/immunization/

PERMISSION AND CONSENT FOR TREATMENT	
Student Name:	
Student Age:	If you under 18, on what date will you turn 18?

PERMISSION FOR TREATMENT OF PERSONS AGE 18 YEARS AND OVER

I certify that the foregoing information is true and complete to the best of my knowledge. I realize that the information that I have given in the medical history section is confidential and for the use of the Health and Counseling Services staff. I understand that the Health and Counseling Service is an integrated facility which offers free medical and mental health services to students, and that my personal health and psychiatric information, including but not limited to symptoms, treatments, medications and diagnoses while I am enrolled as a student, may be disclosed by and between the Health and Counseling Service medical, physical therapy, occupational therapy, nutrition and counseling staff and consultants, on an as needed basis to provide the best possible medical care, which disclosure(s) I hereby authorize without limitation. I give permission to The Juilliard School Health Service to furnish such diagnostic, therapeutic, voluntary immunization, and operative procedures and transportation as may be deemed necessary on my behalf. I am 18 years of age or older. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatment or examination by the Health and Counseling Service staff.

Student's Signature_____Date_____

PERMISSION and CONSENT FOR TREATMENT OF PERSONS UNDER AGE 18 YEARS (MINORS)

If your son/daughter is a minor (under 18 years of age), you as a parent or legal guardian must sign this consent form so that the Health and Counseling Service may promptly carry out appropriate diagnosis and treatment and provide emergency health service procedures with no unnecessary delay. Without a signed permission for treatment, we will not treat your minor son/daughter unless an emergency exists or his/her presenting condition is exempted from requiring parental consent and/or notification by State of New York law. Even with a signed permission for treatment, the Health Service will contact and fully inform you as parent or legal guardian before performing any major diagnostic/treatment procedure except in an emergency. It should be understood that under certain circumstances your son/daughter will be transported to area hospitals for diagnosis and treatment.

I certify that the foregoing information is true and complete to the best of my knowledge. I realize that the information that has been given in the medical history section is confidential and for the use of the Health and Counseling Service staff. I give my permission to The Juilliard School Health and Counseling Service to furnish such diagnostic, therapeutic, voluntary immunization, and operative procedures and transportation as may be deemed necessary for my son/daughter who is under the age of 18 years. I understand that the Health and Counseling Service is an integrated facility which offers free medical and mental health services to students, and that my child's personal health and psychiatric information, including symptoms, treatments, medications and diagnoses while he/she is enrolled as a student, may be disclosed by and between the Health and Counseling Service medical, physical therapy, occupational therapy, nutrition and counseling staff and consultants, on an as needed basis to provide the best possible medical care which disclosure(s) I hereby authorize without limitation. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatment or examination by the Health and Counseling Service staff. As long as the medical treatment considered necessary in the situation is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitations or prohibitions regarding treatment other than the following:

Signature of parent/guardian _____ Date _____

Relationship _____

No treatment will be provided if a signed permission for treatment form is not on file at the Health Services

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TUBERCULOSIS (TB) SCREENING FORM – Please answer the following questions:				
Student Name:				
Have you ever had a positive TB skin test?	Yes	☐	No	☐
Have you ever had close contact with anyone who was sick with TB?	Yes	☐	No	☐
Have you ever lived in one or more of the countries listed below?	Yes	☐	No	☐

If the answer is YES to any of the above questions, The Juilliard School requires that a health care provider complete the Tuberculosis Risk Assessment on the next page (to be completed within 12 months prior to the start of classes.)

If the answer to <u>all</u> of the above questions is NO, no further testing or further action is required.

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia &Herzegovina
Botswana
Brazil
Brunei Darussalam
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Rep.
Chad
China
Colombia
Comoros
Congo
Congo DR
Cote d'Ivoire
Dijbouti
Dominican Repulic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
Hong Kong
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Korea-DPR
Korea-Republic
Kyrgyzstan
Lao PDR
Latvia
Lesotho
Liberia
Libya
Lithuania
Macao
Madagascar
Malawi
Malaysia
Maldives
Mali
a l·fűl·
Marshall lǎfl·yŘă
Mauritania
Mexico
Micronesia
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
b℗ Mariana lǎfl·yŘă
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Qatar
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome & Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Taiwan
Tajikistan
Tanzania-UR
Thailand
Timor-Leste
Togo
Tokelau
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela
Vietnam
Yemen
Zambia
Zimbabwe

Source: WHO

<table>
<tr><td colspan="4">TUBERCULOSIS RISK ASSESSMENT – This form must be completed by a <u>medical provider</u> if you answered Yes to any of the questions on the previous page, the TB Screening Form.</td></tr>
<tr><td colspan="4">Student Name:</td></tr>
<tr><td colspan="2">Step 1: TB Skin Test (PPD) OR TB Blood Test/IGRA</td><td colspan="2">Step 2: Chest X-ray and Medication Treatment</td></tr>
<tr><td>(within 12 months)

Date planted:
___/___/___
Date read:
___/___/___
Interpretation:
NEG POS*
mm of duration: ____</td><td>(within 12 months)
Recommended if prior BCG
Quantiferon
T-Spot
Date: ___/___/___
Result:
NEG POS*
<u>Required:</u>
<u>Attach results</u></td><td>Required if past or current positive TB skin or blood test. Not required if completed medication treatment for TB.
Chest X-ray Date:
___/___/___
Normal Abnormal
<u>Required: Attached X-ray</u></td><td>Latent TB infection
Active TB infection

Date(s): _____
List Medications:</td></tr>
<tr><td colspan="2">*If test is POSTIVE, proceed to Step 2</td><td></td><td></td></tr>
</table>

<table>
<tr><td colspan="3">MEDICAL PROVIDER SIGNATURE – This form must be signed by a licensed MD, DO, PA or NP.
This form may not be signed by a parent.</td></tr>
<tr><td>Signature of Medical Provider</td><td>Date
___/___/___</td><td>Stamp or address</td></tr>
<tr><td>Print Name of Medical Provider</td><td></td><td>License number</td></tr>
</table>

IMMUNIZATION RECORD DUE JULY 15, 2024

You may use official documentation signed by an MD, DO, PA or NP instead of this form.

REQUIREMENTS:

2 Doses of MMR
TB Screening Form, if checked yes also TB Risk Assessment Form
Meningococcal Meningitis Vaccine ACWY (required only if living in the Residence Hall)

PLEASE SEE COLLEGE STUDENT IMMUNIZATION REQUIREMENTS FOR DETAILS: https://www.juilliard.edu/school/about/policies-consumer-information

IMMUNIZATION RECORD – All records must be in English, this form must be completed and signed by a MD, DO, NP or PA.			
Student Name:			
Measles, Mumps, Rubella (MMR) Vaccine - REQUIRED			
Option 1	Measles, Mumps, Rubella (MMR) vaccine – 2 doses	Dose 1 (no more than 4 days prior to first birthday) _____/_____/_____	Dose 2 (at least 28 days after 1st dose) _____/_____/_____
Option 2	Measles (Rubeola) and Dose 1 _____/_____/_____ Dose 2 _____/_____/_____	Rubella and Dose 1 _____/_____/_____	Mumps Dose 1 _____/_____/_____
Option 3	Measles Titer Result positive Mumps Titer Result positive Rubella Titer Result positive *if not immune, must be vaccinated	Date: _____/_____/_____ Date: _____/_____/_____ Date: _____/_____/_____	Attach results Attach results Attach results

Recommended COVID-19 vaccine. Optional, please attach copy of COVID vaccine card or record.				
Date #1 _____/_____/___ Type: _____	Date #2 _____/_____/_____ Type: _____	Date #3 (if applicable) _____/_____/_____ Type: _____	Date #4 (if applicable) _____/_____/_____ Type: _____	Date #5 (if applicable) _____/_____/___ Type: _____

MENINGOCOCCAL MENINGITIS VACCINE ACWY – REQUIRED OF STUDENTS LIVING IN RESIDENCE HALL ONLY (If you cannot access this vaccine outside of the US, email healthservices@juilliard.edu)		
Must be given at age 16 or older	_____/_____/_____	_____/_____/_____

OTHER VACCINES- Not required					
Student Name:					
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Tdap	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Chicken Pox/ Varicella	___/___/___	___/___/___	History of disease: Yes No	Positive titer, attach results ___/___/___	
Hepatitis A	___/___/___	___/___/___			
Hepatitis B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
HPV	HPV 4 HPV 9	___/___/___	___/___/___	___/___/___	
Meningitis B	___/___/___	___/___/___			
Other Vaccines: Type, Dose #, Dates:					

MEDICAL PROVIDER SIGNATURE – This form must be signed by a licensed MD, DO, PA or NP. This form may not be signed by a parent.		
Signature of Medical Provider	Date ___/___/___	Stamp or address
Print Name of Medical Provider		License number

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https://www.juilliard.edu/school/about/policies-consumer-information