Fall 2019

Telephone: 212-799-5000 Ext 282 Fax: 212-769-6427

#### Dear New Juilliard Student:

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. *All documentation must be in English*. Please make a back-up copy of all completed forms.

The <u>completed</u> health form must be returned to the Health Services office by Thursday, August 1, 2019. You will not be able to register for classes on time without completion of these forms. We realize that many students participate in summer festivals away from home. We suggest that you make arrangements to complete the forms, immunizations and testing *BEFORE* you leave for your summer activity so that you are able to file the form with us prior to the deadline.

It is required in New York State to provide incoming college students with information about meningitis. Meningitis is a very serious disease that has affected campuses across the nation. Please carefully read the enclosed information and discuss with your family and your health care practitioner the advisability of getting the vaccination. If you decide you want the protection of the vaccine, we strongly advise you to get it before you arrive at school. Juilliard requires all students living on-campus in the Residence Hall to receive the Meningococcal Meningitis ACWY vaccine.

We strongly encourage you to complete all of the routine childhood vaccinations prior to your enrollment. College students do contract these diseases resulting in serious illness and prolonged absence from class. Additionally, we recommend that you take advantage of the free influenza vaccines that are offered to students annually. You will receive a notice in the Fall about when the flu shots are available.

Juilliard Health and Counseling Services provide free primary health care and psychological services to all enrolled students at the school. Health Services provides medical treatment and preventative care, as well as Physical Therapy, Occupational Therapy, Chiropractic and Nutrition services to aid students in performing their best. Counseling Services provides supportive psychotherapy to assist students in meeting their emotional, psychological, and mental health needs. More information about our services is available on the Juilliard website <a href="http://www.juilliard.edu/campus-life/health-counseling-services">http://www.juilliard.edu/campus-life/health-counseling-services</a>.

Students who are currently under the care of a mental health practitioner, and want to continue with psychotherapy and/or medication at school, should acquaint themselves now with the Juilliard Counseling Service. The Counseling Service provides free weekly counseling sessions to students and there is a staff psychiatrist available for prescribing medication. Counseling Service's phone number is 212-769-3918.

Please do not hesitate to contact us if you have any questions about the enclosed forms, or about the services provided at the Juilliard Health and Counseling Services. Be sure to send completed health forms directly to Health Services, not to Admissions, and do not combine them with any other form that you are returning to Juilliard. (Health Insurance forms go to the Student Accounts Office.) We look forward to meeting you and providing you with excellent primary and mental health care.

Sincerely.

Beth Techow, Administrative Director Health and Counseling Services

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# STUDENT HEALTH RECORD INSTRUCTIONS

# CHECKLIST Completed Health Record is due Aug. 1, 2019.

# Please send in the forms after all of the following are COMPLETE:

- 1. Parts I, II, and VI, your personal information, history and consent for care. If you are under age 18, your parent or legal guardian must sign Parts V & VI.
- 2. Your healthcare provider has completed and signed Part III (Immunization History) and returned the form to you.
- 3. Part IV, the Tuberculosis Screening Form. If the answer is "yes" to any of the questions, the Tuberculosis Risk Assessment must be completed and signed by a healthcare provider and the TB skin test (page 11,#2) or blood test (page 11, #3) must be performed within 12 months prior to arrival at School.
- 4. Part V, Meningococcal Meningitis Vaccination Response Form, required by New York State law. The Meningococcal Meningitis vaccine ACWY (Menactra or Menveo) is required of all students living on-campus in the Residence Hall.
- 5. MAKE A PHOTOCOPY OF THIS COMPLETED FORM AND BRING THE COPY TO SCHOOL WITH YOU IN CASE THE ORIGINAL FORM GETS LOST AND NEEDS TO BE RESUBMITTED.
- 6. We must receive this form by Cwi ww 1, 2019.

Choose one of the following:

Mail this original and signed form to the above address.

Fax this original and signed form to the above fax number.

Upload this original and signed form through the secure Student Health Portal at www.juilliard.edu/studenthealth (you may access this AFTER you receive your Juilliard email address)

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# PART I—STUDENT'S DEMOGRAPHICS

Name: (Last)				
Birth Date: (M/D/Y)/	(First		(Middle)	
Juilliard Division: M If music, please indicate instrume		Dance	Drama —	
Are you a Juilliard graduate?	If YES	S, what month /	year did you gradua	ate?/
Will you live in the Juilliard Resi	dence Hall?	No	Yes	Not sure
Permanent Address:				
City Phone:	State Cell ph	Zip none:	Country	
E-Mail address:				
Name of Parent(s), Spouse, o	or Guardian (chec	ck one):		
Address:				
City Telephone: Home:	State	Zip Work:	Country	
Cell:	E-I	Mail address: _		
Emergency Contact (if a differe	ent person than pa	arent, spouse, o	or guardian listed	above)
Name:		R	telationship to you:	
Address:				
City Telephone: Home:		1	,	
Cell:	E-I			
<b>Healthcare Provider/Clinic that</b> Name:				
Address:				
City Telephone:	State	Zip	Country	Over→

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# PART II —STUDENT'S FAMILY HISTORY

Family History	Year of Birth	Occupation	Health Good /Fair/ Poor	If deceased, specify Cause and Age at Death
Mother				
Father				
Brothers				
Sisters				

## IS THERE A HISTORY OF SIGNIFICANT ILLNESSES IN YOUR FAMILY?

Check each item	No	Yes	Who?	Check each	No	Yes	Who?
				item			
Alcohol or drug				High Blood			
problems/abuse				Pressure			
Asthma				Kidney			
				Disease			
Cancer, leukemia, or				Migraine			
lymphoma							
High Cholesterol				Stroke			
Diabetes mellitus				Sudden death			
				under age 50			
Emotional/Psychological				Tuberculosis			
problems							
Heart attack, disease, or				Other—please			
problem				specify			
Hypermobility/joint							
looseness							

Over→

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# PART II B—PERSONAL HEALTH HISTORY

Student's Name:								
1 . Do you have allergies/adverse reactions to medications/food/insects/other?  No   Yes—please specify								
2. Do you take any	y medications on a fre	quent or regular	basis?					
	escription AND nonpr	escription medic	cations AND supple	ments:				
<u>Name</u>	Dose	Reason for						
	y: eriod monthly? No st (include results, if a	Yes vailable):						
4. Have you had an If yes, include the		ions (including a	ppendectomy, splen	nectomy, tonsillectomy, etc.)?				
5. Do you have a d	isability?							
·	ase explain:							
If Yes, do you auth with Disabilities?	horize us to share this No	disability inform	nation with the Offi	ice of Services for Students				

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# PART II B—PERSONAL HEALTH HISTORY

Student's Name:	
Please check each	item, if yes, please give date and diagnosis.

Condition	Yes	No	Date	If yes, diagnosis/details
Heart disease or murmur				
High blood pressure				
Asthma				
High Cholesterol				
Diabetes				
Transfusion of blood/blood product				
Epilepsy/Seizure disorder				
Migraine				
Radiation treatment to head/neck				
Neck injury/condition				
Lower back injury/condition				
Fracture				
Stress fracture				
Tendon injury/overuse				
Joint injury/overuse				
Muscle injury/overuse				
Chicken Pox/Varicella				
Mononucleosis				
Sexually transmitted diseases				
HIV test positive or AIDS				
Hepatitis (specify A, B, C)				

Over→

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# PART II B—PERSONAL HEALTH HISTORY

Student's Name:
Please check each item, if yes, please give date and diagnosis.

Condition	Yes	No	Date	If yes, diagnosis/details
Alcohol problems				
Drug problems				
Depression				
Anxiety				
Eating disorder/ Anorexia/Bulimia				
Emotional/Psychological Problems				
Other medical or Psychological:				

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#### **PART III**

#### IMMUNIZATION RECORD

Please complete all pages of this form and return to Health and Counseling Services.
PLEASE KEEP A COPY OF THIS FORM FOR YOUR OWN RECORDS
DUE AUGUST 1, 2019

Name:(Last)	(First)	(Middle)				_
Birth Date: (M/D/Y)//	-					
THE FOLLOWING IMMUNIZATION H LICENSED HEALTH CARE PROVIDER Dates must include month, day, and year.	R. ALL RECORI			NED B	Y A	
REQUIRED: -Measles, Mumps, Rubella: 2 doses of MN-TB Risk Assessment must be completed in Students living on-campus in the Residen Meningitis vaccine ACWY (Menactra or I	f patient checked ice Hall are requi	l yes to any question on ired to receive one dose	TB Sci	eening	g (page	
Highly recommended: Tetanus and Pertussis Pox).	within the last ter	n years, and Varicella (if	'you hav	ve not l	nad Chi	cken
A. MMR (Measles, Mumps, Rubella) 1. □ Dose 1			Date:	/		/
2. □ Dose 2			Date:	Month /	Day	Year
B. MEASLES				Month	Day	/ Year
1. ☐ Positive titer (Attach results)			Date:	/		/
<ol><li>☐ Immunized with LIVE measles vaccine</li></ol>	e (If given instead	of MMR)				
Dose 1			Date	/	,	/
D03C 2			Date	/		
C. <u>RUBELLA</u> 1. □Positive titer (Attach results)			Date:	/		/
2. ☐ Immunized with vaccine at 12 months of	of age or later (If	given instead of MMR)	Date:			/
D. MIJMDS						
<ul><li>D. <u>MUMPS</u></li><li>1. □ Positive titer (Attach results)</li></ul>			Date:	/		/
<ol> <li>□ Positive titer (Attach results)</li> <li>□ Immunized with vaccine at 12 months of the control of the</li></ol>	of age or later (If	given instead of MMR).	Date	:	/	/
E. MENINGOCOCCAL MENINGITIS V	VACCINE ACW	Y (Menactra or Menve	o)			
Required for students living on-campus in R Recommended for off-campus students	esidence Hall-one	e dose at age 16 or older	_			
1. □ Dose (age 16 or over)		Da	te:	/	/_	
F. TETANUS-DIPHTHERIA-PERTUSSIS (						
<ol> <li>□ Completed a primary immunization ser</li> <li>□ Received tetanus and pertussis booster</li> </ol>	ies		Dat	e:	_/	_/
2. $\square$ Received tetanus and pertussis booster Specify which type of booster was administe	ered: (ie Td, TDap	)		ت	_/	/

9

## The Juilliard School Health and Counseling Services 60 Lincoln Center Plaza New York, NY 10023

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## Page 2 of IMMUNIZATION FORM

Student's Name:					
G. POLIO  1. Completed primary series of polio im  Type of vaccine: □ oral □ inactivated □			ster)	Date:	
H. CHICKEN POX/VARICELLA (recoll. History of Disease: ☐ Yes ☐ No 2. Varicella antibody Date:/	or Birth in U.S. b	pefore 198 Result: R	80	s □ No Non-reactiv Dose #2: Date	e:
I. HEPATITIS A VACCINE  Dose #1: Date:///					
J. HEPATITIS B VACCINE  1. Dose #1 Date//  2. Hepatitis B surface antibody (Attach	Dose #2 Date results)	/	/	Dose #3 Date Date:	<u>//</u>
L. HPV VACCINE  Dose #1 Date/	Dose #2 Date	/		Dose #3 Date	//
M. OTHER VACCINATIONS: Type, I	Oose #, Dates:				
This form MUST be signed by a lice practitioner signature. Forms withon Please also use practice stamp if available LICENSED HEALTH CARE PROVI	ut signatures and ilable.	l license	numbers		
NAME AND LICENSE NUMBER:_ ADDRESS:	PRINT CLEARLY				License #
City Telephone: ()	State	Zip	Со	untry	
SIGNATURE:				_Date:	

THIS COMPLETED FORM MUST BE RECEIVED BY US NO LATER THAN AUG. 1, 2019.

Mail or fax this form to the address indicated at the top of each page or upload this original and signed form through the secure Student Health Portal at www.juilliard.edu/studenthealth.

You will not be able to register for classes until this information is completed and approved

Health & Immuniz/ Health Record 2019-20 approved.

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# PART IV TUBERCULOSIS (TB) SCREENING FORM

Student's Name:	
Please answer the following questions:	
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 requ	ires 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 all of the above questions is NO, no further testing or further action is required.

Afghanistan Albania Algeria Angola Anguilla Argentina Armenia Azerbaijan Bangladesh Belarus Belize Benin Bhutan Bolivia Bosnia &Herzegovina Botswana Brazil Brunei Darussalam Bulgaria Burkina Faso Burundi Cabo Verde Cambodia Cameroon Central African Rep. Chad China Colombia Comoros Congo	Congo DR Cote d'Ivoire Dijbouti Dominican Republic Ecuador El Salvador Equatorial Guinea Eritrea eSwatini Ethiopia Fiji French-Polynesia Gabon Gambia Georgia Ghana Greenland Guam Guatemala Guinea Guinea-Bissau Guyana Haiti Honduras India Indonesia Iraq Kazakhstan	Kenya Kiribati Korea-DPR Korea-Republic Kuwait Kyrgyzstan Lao PDR Latvia Lesotho Liberia Libya Lithuania Madagascar Malawi Malaysia Maldives Mali Marshall Islands Mauritania Mexico Micronesia Mongolia Morocco Mozambique Myanmar Namibia Nauru Nepal Nicaragua Niger	Nigeria Niue N. Mariana Islands Pakistan Palau Panama Papua New Guinea Paraguay Peru Philippines Portugal 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 Swaziland Taiwan Tajikistan	Tanzania-UR Thailand Timor-Leste Togo Tunisia Turkmenistan Tuvalu Uganda Ukraine Uruguay Uzbekistan Vanuatu Venezuela Vietnam Yemen Zambia Zimbabwe
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Source: WHO Report 2017

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# Page 2 TUBERCULOSIS (TB) RISK ASSESSMENT

Persons with HIV/AIDS

Student's Name:	
This form must be completed by a health care provider if you answered "Ye previous page, the Tuberculosis Screening Form.  The health care provider's signature and licensure should be on the following the street of the street	-
Persons with any of the following risk factors are candidates for either Man Interferon Gamma Release Assay (IGRA), unless a previous positive skin te	
History of a positive TB skin test or IGRA blood test? (If yes, document below) History of BCG vaccination? (If yes, consider IGRA if possible.)	Yes No Yes No
TB Symptom Check Recent close contact with someone with active TB Foreign-born or lived in a high-prevalence area (see previous page for list) Fibrotic changes on a prior chest x-ray suggesting inactive or past TB HIV/AIDS Organ transplant recipient History of intravenous drug use Posident ampleyed or volunteer in a high risk congregate setting	<ul> <li>□ Yes</li> <li>□ No</li> <li>□ Yes</li> <li>□ No</li> <li>□ Unknown</li> <li>□ Yes</li> <li>□ No</li> <li>□ Yes</li> <li>□ No</li> <li>□ Yes</li> <li>□ No</li> </ul>
Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facility, nursing home, homeless shelter, hospital, or other healthcare facility) Immunosuppressed (>15mg/day of prednisone/ TNF-α antagonist for >1 month) Medical history associated with increased risk of progression to active TB if infected [e.g., diabetes, silicosis, cancer, hematologic disease, renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight.]	<ul> <li>□ Yes</li> <li>□ No</li> <li>□ Yes</li> <li>□ No</li> </ul>
<ol> <li>Does the student have signs or symptoms of active TB? ☐ Yes ☐ No</li> </ol>	163 110
If No, proceed to 2 or 3. If Yes, proceed with additional evaluation to exclude including tuberculin skin testing, chest x-ray, and sputum evaluation as indiced.  2. Tuberculin Skin Test (TST) (Within 12 months prior to arrival at School (TST result should be recorded as actual millimeters (MM) of induration, trawrite "0". The TST interpretation should be based on MM of induration as value Given:    Date Read:	eated.  ol.)  Insverse diameter; if no induration,  well as risk factors.)*
Date Given:/ Date Read:// Result: mm of induration *Interpretation: positive	
3. Interferon Gamma release Assay (IGRA) (Within 12 months prior to ar	rival at School.)  QFT-GIT other
4. Chest x-ray: (Required if TST or IGRA is positive)  Date of chest x-ray:/ Result: normal	abnormal
<ul> <li>Recent contact of individual with infectious TB</li> <li>Persons with fibrotic changes on a prior chest x-ray consistent with past TB</li> <li>Recent immigrants (&lt; 5 years) from high-prevalence countries</li> <li>History of injection drug use</li> <li>Mycobacteriology laboratory personnel</li> <li>Current or former resident or worker</li> </ul>	<ul> <li>Persons with no known risk factors for TB disease</li> </ul>
<ul> <li>Organ transplant recipients</li> <li>Immunosuppressed persons</li> <li>Persons with HIV/AIDS</li> <li>Persons with the high-risk medical</li> </ul>	11

conditions

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# Page 3 TUBERCULOSIS (TB) RISK ASSESSMENT

Student's Name:				
This form MUST be signed by a lic practitioner signature. Forms with Please also use practice stamp if a	out signature			
LICENSED HEALTH CARE PRO	OVIDER INF	ORMATION:		Stamp
NAME AND LICENSE NUMBER: ADDRESS:	PRINT CLEA	ARLY		License #
City Telephone: ()	State	Zip	Country	
SIGNATURE:			Date:	

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#### **PART V**

## Meningococcal Meningitis ACWY (Menactra or Menveo) Vaccination Response Form

Instructions: To complete this form, please check one of the boxes and sign at the bottom.

New York State Public Health Law requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quarter, complete and return the following form to Juilliard Health Services.

The Juilliard School requires that students living on-campus in the Residence Hall receive one dose of Meningococcal Meningitis vaccine ACWY (Menactra or Menveo) at age 16 or older. We highly recommend this vaccine for off campus students.

Health Services encourages students to receive this vaccine from their private health care provider **before** they come to school. A record of the vaccination must be sent by mail or fax to Health Services.

#### Check one box and sign below.

I have	(for students under the age of 18: My child has):			
	had meningococcal immunization ACWY (Menactra record is attached.	or Menveo) within the	past 5 years.	The vaccine
	[Note: The Advisory Committee on Immunization Practices recyears should have at least 1 dose of Meningococcal ACWY vac or after their 16 <sup>th</sup> birthday, and that young adults aged 16 throug vaccine series. College and university students should discuss the	cine not more than 5 years gh 23 years may choose to r	before enrollmer receive the Meni	nt, preferably on ngococcal B
	read, or have had explained to me, the information re 16). I understand the risks of not receiving the vaccin obtain immunization against meningococcal disease.			
THIS	FORM MUST HAVE A SIGNATURE			
Signed If stude	nt is a minor, this form must be signed by a parent or guardian. P		ship to the stude	
Print S	rudent's name	Student Date of Birth	/ /	

on

Date

## The Juilliard School Health and Counseling Services 60 Lincoln Center Plaza New York, NY 10023

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#### PART VI—PERMISSION and CONSENT FOR TREATMENT

IF YOU ARE CURRENTLY UNDER THE AGE OF EIGHTEEN YEARS, YOUR PARENT OR GUARDIAN MUST SIGN BELOW. If you are not 18, PLEASE INDICATE HERE THE MONTH, DAY, YEAR THAT YOU WILL BE 18 YEARS OLD:

I will be eighteen years		
old on:		
// 20		
Month Day Year		
•		

#### PERMISSION FOR TREATMENT OF PERSONS AGE 18 YEARS AND OVER

Student's Signature\_\_\_\_\_

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.

PERMISSION and CONSENT FOR TREATMENT OF PERSO	NS UNDER AGE 18 YEARS (MINORS)
PERMISSION and CONSENT FOR TREATMENT OF PERSO If your son/daughter is a minor (under 18 years of age), you as a possible medical care which disclosure(s) I hereby a provide the best possible medical type of injury or illness involved, I impose no specific limit other than the following (if none, so state):	parent or legal guardian must sign this consent out appropriate diagnosis and treatment and clay. Without a signed permission for treatment, is or his/her presenting condition is exempted York law. Even with a signed permission for rent or legal guardian before performing any and be understood that under certain is for diagnosis and treatment. It is to f my knowledge. I realize that the fidential and for the use of the Health and coll Health and Counseling Service to furnish such address and transportation as may be deemed address and that the Health and Counseling I health services to students, and that my child's exatments, medications and diagnoses while Health and Counseling Service medical, iff and consultants, on an as needed basis to authorize without limitation. I am aware that the mo guarantees have been made to me as to the vice staff. As long as the medical treatment of accepted standards of medical practice for the
Signature of parent/guardian	Date: / /

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

Relationship



# **Meningococcal Disease**

## What is meningococcal disease?

Meningococcal disease is caused by bacteria called Neisseria meningitidis. It can lead to serious blood infections. When the linings of the brain and spinal cord become inflamed, it is called meningitis. The disease strikes quickly and can have serious complications, including death.

Anyone can get meningococcal disease. Some people are at higher risk. This disease occurs more often in people who are:

- · Teenagers or young adults
- · Infants younger than one year of age
- · Living in crowded settings, such as college dormitories or military barracks
- Traveling to areas outside of the United States, such as the "meningitis belt" in Africa
- · Living with a damaged spleen or no spleen
- Being treated with Soliris® or, who have complement component deficiency (an inherited immune disorder)
- · Exposed during an outbreak
- · Working with meningococcal bacteria in a laboratory

## What are the symptoms?

Symptoms appear suddenly – usually 3 to 4 days after a person is infected. It can take up to 10 days to develop symptoms. Symptoms may include:

- · A sudden high fever
- · Headache
- Stiff neck (meningitis)
- · Nausea and vomiting
- Red-purple skin rash
- · Weakness and feeling very ill
- · Eyes sensitive to light

# How is meningococcal disease spread?

It spreads from person-to-person by coughing or coming into close or lengthy contact with someone who is sick or who carries the bacteria. Contact includes kissing, sharing drinks, or living together. Up to one in 10 people carry meningococcal bacteria in their nose or throat without getting sick.

#### Is there treatment?

Early diagnosis of meningococcal disease is very important. If it is caught early, meningococcal disease can be treated with antibiotics. But, sometimes the infection has caused too much damage for antibiotics to prevent death or serious long-term problems. Most people need to be cared for in a hospital due to serious, life-threatening infections.

# What are the complications?

Ten to 15 percent of those who get meningococcal disease die. Among survivors, as many as one in five will have permanent disabilities. Complications include:

- · Hearing loss
- · Brain damage
- Kidney damage
- Limb amputations

# What should I do if I or someone I love is exposed?

If you are in close contact with a person with meningococcal disease, talk with your health care provider about the risk to you and your family. They can prescribe an antibiotic to prevent the disease.

# What is the best way to prevent meningococcal disease?

The single best way to prevent this disease is to be vaccinated. Vaccines are available for people 6 weeks of age and older. Various vaccines offer protection against the five major strains of bacteria that cause meningococcal disease:

- All teenagers should receive two doses of vaccine against strains A, C, W and Y. The first dose is given at 11 to 12 years of age, and the second dose (booster) at age 16.
  - It is very important that teens receive the booster dose at age 16 in order to protect them through the years when they are at greatest risk of meningococcal disease.
  - Talk to your health care provider today if your teen has not received two doses of vaccine against meningococcal strains A, C, W and Y.
- Teens and young adults can also be vaccinated against the "B" strain. Talk to your health care provider about whether they recommend vaccine against the "B" strain.

Others who should receive the vaccine include:

- · Infants, children and adults with certain medical conditions
- · People exposed during an outbreak
- Travelers to the "meningitis belt" of sub-Saharan Africa
- · Military recruits

Please speak with your health care provider if you may be at increased risk.

# What are the meningococcal vaccine requirements for school attendance?

As of September 1, 2016, children entering grades 7 and 12 must be immunized against meningococcal disease strains A, C, W and Y according to the recommendations listed above.

## Is there an increased risk for meningococcal disease if I travel?

- Meningococcal disease and outbreaks occur in the United States and around the world. The disease is more common in the "meningitis belt" of sub-Saharan Africa. The risk is highest in people who visit these countries and who have prolonged contact with local populations during an epidemic.
- To reduce your risk of illness, wash your hands often, maintain healthy habits such as getting plenty of rest and try not to come into contact with people who are sick.

#### Travel and meningococcal disease:

wwwnc.cdc.gov/travel/diseases/meningococcal-disease

#### Learn more about meningococcal disease:

www.cdc.gov/meningococcal/

For more information about vaccine-preventable diseases: www.health.ny.gov/prevention/immunization/

#### **Bureau of Immunization**

New York State Department of Health

# The Juilliard School

#### STUDENT IMMUNIZATION REQUIREMENTS

All new full and part-time undergraduate and graduate students enrolled in a program of study leading to an academic degree at any 4-year public or independent institution of higher education in New York State are required to provide evidence of immunization as a prerequisite to enrollment and/or continued college or university attendance beyond 30 days (45 days for out-of state students) as follows:

**Measles**: A certificate of immunization that shows the student has either:

(i) received two doses of live measles virus vaccine, the first dose given no more than 4 days prior to student's 1<sup>st</sup> birthday and the second dose administered more than 28 days after the first dose; or
(ii) been diagnosed by a physician, physician assistant, or nurse practitioner as having had measles disease; or

(iii) demonstrated serological evidence of measles antibodies (student must attach copy of lab report); or

(iv) if the student is unable to provide a certificate of immunization that satisfies the requirements in (i), (ii) or (iii) above, documentation that proves the student attended primary or secondary school in the United States after 1980 will be sufficient proof that the student received one dose of live measles virus vaccine. If such documentation is provided, then the student must also provide a certificate of immunization that documents a dose of measles vaccine was administered within one year of attendance at the post-secondary institution; and

**Rubella**: A certificate of immunization that shows the student has either:

(i) received a single dose of live rubella virus vaccine given no more than 4 days prior to student's 1<sup>st</sup> birthday; or (ii) been diagnosed by a physician, physician assistant, or nurse practitioner as having had rubella disease; or

(iii) demonstrated serological evidence of rubella antibodies (student must attach copy of lab report); and

**Mumps:** A certificate of immunization that shows the student has either:

(i) received a single dose of live mumps virus vaccine given no more than 4 days prior to student's 1<sup>st</sup> birthday; or

(ii) been diagnosed by a physician, physician assistant, or nurse practitioner as having had mumps disease; or

(iii) demonstrated serological evidence of mumps antibodies (student must attach copy of lab report)

Or: The student provides a certificate of immunization that shows the student is in the process of completing the above requirements and:

(1) has received at least one dose of live measles virus vaccine as required; and

(2) has complied with the requirements for <u>mumps</u> and <u>rubella</u>; and (3) has an appointment to return to a health <u>practitioner</u> for the second measles immunization, if this appointment is scheduled for no more than 90 days since administration of the first dose of measles virus vaccine.

Documented proof of immunity <u>must</u> be submitted to Health and Counseling Services. <u>Failure to submit the required</u> documentation will result in a registration hold. Students who arrive at School without required documentation, and who fail to respond to a Final Notice will be called to the Dean's Office, and may be dismissed from the School for failure to abide by School rules as set forth in the Student Handbook. You can send or fax original documentation signed by a licensed health care provider, a copy of a signed and authorized school record, or the completed and signed Student Immunization Record form to Health Services.

#### Meningococcal Meningitis Vaccine Requirements-New York State law

New York law requires all students attending post-secondary institutions for six or more credit hours per semester to produce a record of meningococcal meningitis ACWY (Menactra or Menveo) immunization within the past five years, or to sign an acknowledgment of meningococcal disease risks and refusal of meningococcal meningitis immunization. Students must also sign a document acknowledging their receipt of disease and vaccine information. New York law mandates that no institution should permit any student to attend the institution in excess of 30 days without complying with this law. ALL STUDENTS MUST SIGN THE ENCLOSED MENINGITIS RESPONSE FORM.

#### Juilliard Requirements

**Tuberculosis Screening Requirement** 

The Juilliard School requires all enrolled students to complete the Tuberculosis Screening Form. If the answer is yes to any of the questions, the Tuberculosis Risk Assessment must be completed and signed by a health care provider.

Meningococcal Meningitis Vaccine Requirements for Students Living on Campus – Juilliard

The Juilliard School requires all students living on-campus in the Residence Hall to provide documentation of one dose of the meningococcal meningitis vaccine ACWY (Menactra or Menveo) at age 16 or older.

#### Exemptions from Immunizations-Please contact Juilliard Health Services to get a copy of the required Immunization Waiver form.

Medical Exemption: If any licensed physician, licensed midwife (caring for a pregnant student), physician assistant or nurse practitioner certifies in writing that one or more of the required immunizations may be detrimental to the student's health or is otherwise medically contraindicated, the above requirements shall be waived until such immunization is determined no longer to be detrimental to the student's health or otherwise medically contraindicated. This statement must specify those immunizations which may be detrimental and the length of time they may be detrimental. Juilliard requires a medical provider statement regarding the elements of student's medical history or condition relevant to the medical exemption.

Religious Exemption: A written and signed statement from the student or in the event that the student is a minor, from their parent or guardian, that they hold sincere and genuine religious beliefs which prohibit immunization of the student. When a religious exemption is claimed, Juilliard may require supporting documents.