The Juilliard School
Health and Counseling Services
60 Lincoln Center Plaza
New York, NY 10023
Phone: 212-799-5000 Ext 282 Email: healthservices@juilliard.edu

Fall 2020

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 completed health form must be returned to the Health Services office by August 1, 2020. You will not be able to register for classes on time without completion of these forms. Please begin this form as soon as possible.

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 https://www.juilliard.edu/campus-life/well-being/health-and-counseling-services .

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, 2020.

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 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 August 1, 2020.**

Choose one of the following:
Preferred:
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) or
Mail this original and signed form to the above address.

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PART I—STUDENT'S DEMOGRAPHICS

Name: _____
(Last) (First) (Middle)

Birth Date: (M/D/Y) _____/_____/ _____ Gender: _____

Juilliard Division: ☐ Music ☐ Dance ☐ Drama
If music, please indicate instrument:_____

Are you a Juilliard graduate? _____If YES, what month /year did you graduate? _____/_____

Will you live in the Juilliard Residence Hall? ☐ No ☐ Yes ☐ Not sure

Permanent Address:_____

_____
City State Zip Country
Phone: _____ Cell phone: _____

E-Mail address: _____

Name of ☐ Parent(s), ☐ Spouse, or ☐ Guardian (check one):_____

Address: _____

_____
City State Zip Country
Telephone: Home: _____ Work: _____

Cell: _____ E-Mail address: _____

Emergency Contact (if a different person than parent, spouse, or guardian listed above)

Name: _____Relationship to you:_____

Address: _____

_____
City State Zip Country
Telephone: Home: _____ Work: _____

Cell: _____ E-Mail address: _____

Healthcare Provider/Clinic that you usually consult for medical care:
Name: _____

Address: _____

_____
City State Zip Country
Telephone: _____

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PART II —STUDENT'S FAMILY HISTORY

Student's Name: _____

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 item**	**No**	**Yes**	**Who?**
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			
Hypermobility/joint looseness							

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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 medications on a frequent or regular basis?
☐No ☐Yes
Please list ALL prescription AND nonprescription medications AND supplements:

Name	**Dose**	**Reason for taking**

3. For females only:
Do you get your period monthly? ☐No ☐Yes
Date of last Pap test (include results, if available):

_____

4. Have you had any surgeries or operations (including appendectomy, splenectomy, tonsillectomy, etc.)? If yes, include the type and date.

_____

_____

5. Do you have a disability?
☐No ☐Yes- Please explain:

_____

If Yes, do you authorize us to share this disability information with the Office of Academic Support and Disability Services? ☐No ☐Yes

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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)				

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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 KEEP A COPY OF THIS FORM FOR YOUR OWN RECORDS
You may use official documentation signed by a MD, DO, PA or NP instead of this form.
DUE AUGUST 1, 2020

Name: _____
(Last) (First) (Middle)
Birth Date: (M/D/Y) _____/_____/ _____

THE FOLLOWING IMMUNIZATION HISTORY MUST BE COMPLETED AND SIGNED BY A LICENSED HEALTH CARE PROVIDER. ALL RECORDS MUST BE IN ENGLISH.
Dates must include month, day, and year.

REQUIRED:
-Measles, Mumps, Rubella: 2 doses of MMR or 2 doses of Measles and one dose each of Rubella and Mumps.
-TB Risk Assessment must be completed if patient checked yes to any question on TB Screening (page 10).
-Students living on-campus in the Residence Hall are required to receive one dose of Meningococcal Meningitis vaccine ACWY at age 16 or older.

Highly recommended: Tetanus and Pertussis within the last ten years, and Varicella (if you have not had Chicken Pox).

A. **MMR** (Measles, Mumps, Rubella)
1. ☐ Dose 1……..Date: _____/_____/_____ (Month Day Year)
2. ☐ Dose 2 ……Date: _____/_____/_____ (Month Day Year)

B. **MEASLES**
1. ☐ Positive titer (Attach results)…….……..…….... Date: _____/_____/_____
2. ☐ Immunized with **LIVE** measles vaccine (If given instead of MMR)
Dose 1…….Date_____/_____/_____
Dose 2…….Date_____/_____/_____

C. **RUBELLA**
1. ☐Positive titer (Attach results) ……..…….…….Date: _____/_____/_____
2. ☐ Immunized with vaccine at 12 months of age or later (If given instead of MMR)…..Date:_____/_____/_____

D. **MUMPS**
1. ☐ Positive titer (Attach results)……...…….Date:_____/_____/_____
2. ☐ Immunized with vaccine at 12 months of age or later (If given instead of MMR)…...Date: _____/_____/_____

E. MENINGOCOCCAL MENINGITIS VACCINE ACWY
Required for students living on-campus in Residence Hall-one dose at age 16 or older
Recommended for off-campus students
1. ☐ Dose (age 16 or over)……...Date:_____ /_____ /_____

F. TETANUS-DIPHTHERIA-PERTUSSIS (recommended)
1. ☐ Completed a primary immunization series……..Date: _____/_____/_____
2. ☐ Received tetanus and pertussis booster within the last 10 years …….……...Date:_____/_____/_____
Specify which type of booster was administered: (ie Td, TDap) _____

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Page 2 of IMMUNIZATION FORM

Student's Name: _____

G. POLIO
1. Completed primary series of polio immunization: ☐ Yes ☐ No
Type of vaccine: ☐ oral ☐ inactivated ☐ E-IPV (Date of Last Booster)…….. Date: _____/_____/_____

H. CHICKEN POX/VARICELLA (recommended)
1. History of Disease: ☐ Yes ☐ No or Birth in U.S. before 1980 ☐ Yes ☐ No
2. Varicella antibody Date:_____/_____/_____ Result: Reactive:_____ Non-reactive:_____
3. Immunized with vaccine……Dose #1: Date _____/_____/_____ Dose #2: Date _____/_____/_____

I. HEPATITIS A VACCINE
Dose #1: Date: _____ /_____ /_____ Dose #2: Date: _____ /_____ /_____

J. HEPATITIS B VACCINE
1. Dose #1 Date _____/_____/_____ Dose #2 Date _____/_____/_____ Dose #3 Date _____/_____/_____
2. Hepatitis B surface antibody (Attach results)……..……Date:_____/_____/_____

L. HPV VACCINE
Dose #1 Date _____/_____/_____ Dose #2 Date _____/_____/_____ Dose #3 Date. _____/_____/_____

M. OTHER VACCINATIONS: Type, Dose #, Dates:
_____

_____

This form MUST be signed by a licensed MD, DO, PA, or NP; license number *must* be indicated after practitioner signature. <u>Forms without signatures and license numbers will not be approved</u>.
Please also use practice stamp if available. This form may not be signed by a parent doctor.

LICENSED HEALTH CARE PROVIDER INFORMATION: *Stamp*

NAME AND LICENSE NUMBER:_____
PRINT CLEARLY License #
ADDRESS: _____

_____
City State Zip Country
Telephone: (_____)_____

<u>SIGNATURE</u>: _____Date: _____

THIS COMPLETED FORM MUST BE RECEIVED BY US NO LATER THAN AUG. 1, 2020. Preferred: upload this original and signed form through the secure Student Health Portal at www.juilliard.edu/studenthealth or Mail this form to the address indicated at the top of each page You will not be able to register for classes until this information is completed and 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 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	Congo DR	Kenya	Nigeria	Tanzania-UR
Albania	Cote d'Ivoire	Kiribati	Niue	Thailand
Algeria	Dijbouti	Korea-DPR	N. Mariana Islands	Timor-Leste
Angola	Dominican Republic	Korea-Republic	Pakistan	Togo
Anguilla	Ecuador	Kuwait	Palau	Tunisia
Argentina	El Salvador	Kyrgyzstan	Panama	Turkmenistan
Armenia	Equatorial Guinea	Lao PDR	Papua New Guinea	Tuvalu
Azerbaijan	Eritrea	Latvia	Paraguay	Uganda
Bangladesh	eSwatini	Lesotho	Peru	Ukraine
Belarus	Ethiopia	Liberia	Philippines	Uruguay
Belize	Fiji	Libya	Portugal	Uzbekistan
Benin	French-Polynesia	Lithuania	Qatar	Vanuatu
Bhutan	Gabon	Madagascar	Republic of Moldova	Venezuela
Bolivia	Gambia	Malawi	Romania	Vietnam
Bosnia &Herzegovina	Georgia	Malaysia	Russian Federation	Yemen
Botswana	Ghana	Maldives	Rwanda	Zambia
Brazil	Greenland	Mali	Sao Tome & Principe	Zimbabwe
Brunei Darussalam	Guam	Marshall Islands	Senegal	
Bulgaria	Guatemala	Mauritania	Sierra Leone	
Burkina Faso	Guinea	Mexico	Singapore	
Burundi	Guinea-Bissau	Micronesia	Solomon Islands	
Cabo Verde	Guyana	Mongolia	Somalia	
Cambodia	Haiti	Morocco	South Africa	
Cameroon	Honduras	Mozambique	South Sudan	
Central African Rep.	India	Myanmar	Sri Lanka	
Chad	Indonesia	Namibia	Sudan	
China	Iraq	Nauru	Suriname	
Colombia	Kazakhstan	Nepal	Swaziland	
Comoros		Nicaragua	Taiwan	
Congo		Niger	Tajikistan	

Source: WHO Report 2017

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Page 2 TUBERCULOSIS (TB) RISK ASSESSMENT

Student's Name: _____

This form must be completed by a health care provider if you answered "Yes" to any of the questions on the previous page, the Tuberculosis Screening Form.
The health care provider's signature and licensure should be on the following page.

Persons with any of the following risk factors are candidates for either Mantoux tuberculin skin test (TST or Interferon Gamma Release Assay (IGRA, unless a previous positive skin test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) __Yes __ No
History of BCG vaccination? (If yes, consider IGRA if possible.) __Yes __ No

TB Symptom Check

Recent close contact with someone with active TB ☐ Yes ☐ No
Foreign-born or lived in a high-prevalence area (see previous page for list) ☐ Yes ☐ No

Fibrotic changes on a prior chest x-ray suggesting inactive or past TB ☐ Yes ☐ No ☐ Unknown
HIV/AIDS ☐ Yes ☐ No
Organ transplant recipient ☐ Yes ☐ No
History of intravenous drug use ☐ Yes ☐ No
Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facility, nursing home, homeless shelter, hospital, or other healthcare facility) ☐ Yes ☐ No
Immunosuppressed (>15mg/day of prednisone/ TNF-α antagonist for >1 month) ☐ Yes ☐ No
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.] ☐ Yes ☐ No

1. **Does the student have signs or symptoms of active TB?** ☐ Yes ☐ No
   If No, proceed to 2 or 3. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.
2. **Tuberculin Skin Test (TST) (Within 12 months prior to arrival at School.)**
   (TST result should be recorded as actual millimeters (MM) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on MM of induration as well as risk factors.)*
   Date Given: _____/_____/_____ Date Read: _____/_____/_____
   Result: _____ mm of induration *Interpretation: positive _____ negative _____

   Date Given: _____/_____/_____ Date Read: _____/_____/_____
   Result: _____ mm of induration *Interpretation: positive _____ negative _____
3. **Interferon Gamma release Assay (IGRA) (Within 12 months prior to arrival at School.)**
   Date Obtained: _____/_____/_____ (specify method) QFT-G QFT-GIT other _____
   Result: negative _____ positive_____ intermediate _____
4. **Chest x-ray: (Required if TST or IGRA is positive)**
   Date of chest x-ray: _____/_____/_____ Result: normal _____ abnormal _____

*** TST Interpretation guidelines**

>5 mm is positive:
- Recent contact of individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray consistent with past TB
- Organ transplant recipients
- Immunosuppressed persons
- Persons with HIV/AIDS

>10 mm is positive:
- Recent immigrants (< 5 years) from high-prevalence countries
- History of injection drug use
- Mycobacteriology laboratory personnel
- Current or former resident or worker in high-risk congregate settings
- Persons with the high-risk medical conditions

>15 mm is positive:
- Persons with no known risk factors for TB disease

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Page 3 TUBERCULOSIS (TB) RISK ASSESSMENT

Student's Name: _____

This form MUST be signed by a licensed MD, DO, PA, or NP; license number *must* be indicated after practitioner signature. Forms without signatures and license numbers will not be approved.
Please also use practice stamp if available.

LICENSED HEALTH CARE PROVIDER INFORMATION: *Stamp*

NAME AND LICENSE NUMBER: _____
PRINT CLEARLY License #

ADDRESS: _____

_____
City State Zip Country

Telephone: (_____)_____

SIGNATURE: _____Date: _____

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PART V
Meningococcal Meningitis ACWY 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 at age 16 or older. We highly recommend this vaccine for off campus students.

Students should receive this vaccine from their private health care provider **before** they come to school. If it is not available in your country, please contact Health Services. A record of the vaccination must be uploaded or sent by mail 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 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 (see pages 15-16). I understand the risks of not receiving the vaccine. I have decided that I (my child) will **not** obtain immunization against meningococcal disease.

THIS FORM MUST HAVE A SIGNATURE

Signed _____ Date _____
If student is a minor, this form must be signed by a parent or guardian. Please indicate your relationship to the student.

Print Student's name _____ Student Date of Birth ____/____/____

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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

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 Service

NEW YORK STATE | Department of Health

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/

STUDENT IMMUNIZATION REQUIREMENTS

Documented proof of immunity must be submitted to Health Services by August 1, 2020. Failure to submit the required 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.

Students may upload or mail original documentation signed by a licensed health care provider(MD, DO, PA or NP), a copy of a signed and authorized school record, or the completed and signed Student Immunization Record form to Health Services.

New York State Requirements

All new full and part-time undergraduate and graduate students enrolled for 6 or more credit hours 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
Students born on or after January 1, 1957 must submit proof of immunity to measles. Only one of the following is required:
•The student must submit proof of two doses of live measles vaccine: the first dose given no more than 4 days prior to the student's first birthday and the second at least 28 days after the first dose; or
•The student must submit serological proof of immunity to measles. This means the demonstration of measles antibodies through a blood test performed by an approved medical laboratory (student must attach lab report); or
•The student must submit a statement from the diagnosing physician that the student has had measles disease.

Mumps
Students born on or after January 1, 1957 must submit proof of immunity to mumps. Only one of the following is required:
•The student must submit proof of one dose of live mumps vaccine given no more than 4 days prior to the student's first birthday; or
•The student must submit serological proof of immunity to mumps. This means the demonstration of mumps antibodies through a blood test performed by an approved medical laboratory (student must attach lab report).

Rubella
Students born on or after January 1, 1957 must submit proof of immunity to rubella. Only one of the following is required:
•The student must submit proof of one dose of live rubella vaccine given no more than 4 days prior to the student's first birthday; or
•The student must submit serological proof of immunity to rubella. This means the demonstration of rubella antibodies through a blood test performed by an approved medical laboratory (Since rubella rashes resemble rashes of other diseases, it is impossible to diagnose reliably on clinical grounds alone. Serological evidence is the only permissible alternative to immunization.);

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 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, incluidng TB testing within 12 months prior to starting school 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 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 a licensed physician or nurse practitioner, or licensed midwife caring for a pregnant student certifies in writing that the student has a health condition which is a valid contraindication to receiving a specific vaccine, then a permanent or temporary (for resolvable conditions such as pregnancy) exemption may be granted. 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.