Pre-Enrollment Health Packet

2017-2018 Academic Year

PRE-ENROLLMENT HEALTH PACKET CHECKLIST

Congratulations on your acceptance to the San Francisco Conservatory of Music! Prior to your enrollment at the Conservatory, information about your health and immunization status is required by Conservatory policy and California law to be submitted to the Office of Student Affairs. ***This health information is required of all new students.*** This completed information will be held in the Office of Student Affairs and not within your academic record.

Please utilize the checklist below to ensure that all of the necessary details for your Pre-Enrollment Health Packet have been completed and are included. **Your completed Pre-Entrance Health Packet must be submitted to the Office of Student Affairs by July 14, 2017** (or December 15, 2017 for Spring Semester 2018 enrollment).

- ☐ Complete *Pre-Enrollment Health Record* with your health care professional, including up-to-date immunization/screening information:
    - ☐ Records and appropriate boosters for immunizations, including:
        - ☐ Measles, Mumps, and Rubella vaccine (MMR), and
        - ☐ Tetanus, Diphtheria, Pertussis (TDaP) vaccine/booster dose, and
        - ☐ Varicella (chicken pox) vaccine (Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement), and
        - ☐ Review other recommended vaccines
    - ☐ Completed *Tuberculosis (TB) Screening Questionnaire* and, if applicable, *Tuberculosis Risk Assessment*
    - ☐ Completed *Hepatitis A & B Immunization Record / Waiver* form
    - ☐ Completed *Meningococcal Disease Immunization Record / Waiver* form
- ☐ Complete *Pre-Enrollment Health Packet Signature Form*
- ☐ Retain a copy of the *Pre-Enrollment Health Packet* for your records

Additionally, be aware that in the month of July, information on online enrollment in (or waiver of) the *Conservatory's Student Health Insurance Plan* will be sent by email. See information online at http://www.sfcm.edu/student-health-insurance-plan. You may still complete this packet before enrolling/waiving the health insurance plan.

Failure to return the completed *Pre-Enrollment Health Packet* and enroll in (or waive) the Conservatory's Student Health Insurance Plan will prevent a student from registering for classes.

Please return the completed *Packet* to the address below. Please do not enclose it with other Conservatory correspondence to ensure that it confidentially reaches the Office of Student Affairs in a timely manner. For additional information, or if you have questions, contact the Office of Student Affairs at (415) 503-6281.

Office of Student Affairs
San Francisco Conservatory of Music
50 Oak Street
San Francisco, CA 94102

PRE-ENROLLMENT HEALTH RECORD

STUDENT INFORMATION

Last/Family Name: ___________________________________ First/Given Name: ______________________________

Date of Birth: (Month/Day/Year) ____/____/________ Gender: ___________________

Home/PO Box/Street Address: ____

City, State, Zip, Country: ____ Telephone: _______________________

Level: □ Undergraduate (BM) □ Graduate (MM) □ Postgraduate / Professional Studies Diploma, or Artist Certificate
Residency: □ Domestic □ International / US Citizen Living Abroad

PROOF OF REQUIRED IMMUNIZATIONS

To be completed by your health care professional, ***or*** attach immunization records (must be in English) that show the following required immunizations. Your health care provider's signature is required at the end of this *Pre-Enrollment Health Record*, if you are not attaching copies of your records.

MEASLES, MUMPS, AND RUBELLA (MMR)

MMR vaccine: Dose #1 (Month/Day/Year): ____/____/________ Dose #2 (Month/Day/Year): ____/____/________
If proof of immunization for MMR is not available, a blood titer showing immunity will be accepted:
Date of Measles titer (Month/Day/Year): ____/____/________ Result: □ Immune □ Not immune
Date of Mumps titer (Month/Day/Year): ____/____/________ Result: □ Immune □ Not immune
Date of Rubella titer (Month/Day/Year): ____/____/________ Result: □ Immune □ Not immune

TETANUS, DIPHTHERIA, PERTUSSIS (TDaP)

Primary series completed? Date of Last Dose in Series (Month/Day/Year): ____/____/________

Date of Most Recent Booster Dose (Month/Day/Year): ____/____/________
Type of Booster: □ TD □ TDaP (TDaP booster recommended for ages 11 to 64, unless contraindicated)

VARICELLA (CHICKEN POX)

(Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, *or* two doses of vaccine meets the requirement.)

1. History of Disease: □ Yes □ No , or Birth in the U.S. before 1980: □ Yes □ No

2. Varicella antibody (Month/Day/Year): ____/____/________ Result: □ Reactive □ Non-reactive

3. Immunization: Dose #1 (Month/Day/Year): ____/____/________ Dose #2 (Month/Day/Year): ____/____/________
Dose #2 given at least 12 weeks after first dose (ages 1-12 years) or at least 4 weeks after first dose (if age 13 years or older)

RECOMMENDED VACCINATIONS

The Conservatory adopts the American College Health Association guidelines and recommends: an annual Influenza vaccination, the Polio Vaccine (for certain international travelers from areas or countries where polio is epidemic or endemic), and the Human Papillomavirus Vaccine (females 11 or 12 years old, females 13-26 years old who have not received the vaccine previously; males 11 or 12 years old, and males 13-21 years old who have not received the vaccine previously). Please consult with your health care provider.

PRE-ENROLLMENT HEALTH RECORD (Continued)

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

Please answer the following questions:

1. Have you ever had a positive TB skin test? □ Yes □ No
2. Have you ever had close contact with anyone who was sick with TB? □ Yes □ No
3. Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? □ Yes □ No
(If yes, please CIRCLE the country)
4. Have you ever traveled* to/in one or more of the countries listed below? □ Yes □ No
**The significance of the travel exposure should be discussed with a health care provider and evaluated.* (If yes, please CHECK the country/ies)
5. Have you ever been vaccinated with BCG? □ Yes □ No

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2009.
Countries with incidence rates of ≥ 20 cases per 100,000 population.

If the answer is YES to any of the above questions, the Conservatory requires that a health care provider complete the *Tuberculosis Risk Assessment* on the next page (to be completed on or after March 15, 2017, or 6 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 (skip to Page 7).

PRE-ENROLLMENT HEALTH RECORD (Continued)

TUBERCULOSIS (TB) RISK ASSESSMENT

See box at end of Page 4; to be completed by your health care professional.
Persons with any of the following are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented:

RISK FACTORS

Recent close contact with someone with infectious TB disease	□ Yes □ No
Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America) ** The significance of the travel exposure should be discussed with a health care provider and evaluated.*	□ Yes □ No
Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease	□ Yes □ No
HIV/AIDS	□ Yes □ No
Organ transplant recipient	□ Yes □ No
Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF-α antagonist)	□ Yes □ No
History of illicit drug use	□ Yes □ No
Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)	□ Yes □ No
Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)]	□ Yes □ No

1. Does the student have signs or symptoms of active tuberculosis disease?

No _____ Proceed to items 2 *or* 3 on Page 6.

Yes _____ Proceed to Page 6 with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

(continued on next page)

PRE-ENROLLMENT HEALTH RECORD (Continued)

TUBERCULOSIS (TB) RISK ASSESSMENT (Continued)

To be completed by your health care professional on or after March 15, 2017, or 6 months prior to the start of classes.

2. Tuberculin Skin Test (TST)

(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 (Month/Day/Year): ____/____/________ Date Read (Month/Day/Year): ____/____/________

Result: ________ mm of induration **Interpretation: □ positive □ negative

3. Interferon Gamma Release Assay (IGRA)

Date Obtained (Month/Day/Year): ____/____/________ (specify method) QFT-G QFT-GIT T-Spot other_____

Result: □ negative □ positive □ indeterminate □ borderline (T-Spot only)

4. Chest X-ray: (Required if TST or IGRA is positive)

Date of chest x-ray (Month/Day/Year): ____/____/________ Result: □ normal □ abnormal

**Interpretation guidelines

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- Organ transplant recipients
- Immunosuppressed persons: taking > 15 mg/d of prednisone for > 1 month; taking a TNF-α antagonist
- Persons with HIV/AIDS

>10 mm is positive:

- Persons born in a high prevalence country or who resided in one for a significant* amount of time
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of resident, worker, or volunteer in high-risk congregate settings
- Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

>15 mm is positive:

- Persons with no known risk factors for TB disease

**The significance of the exposure should be discussed with a health care provider and evaluate*

PRE-ENROLLMENT HEALTH RECORD (Continued)

HEPATITIS A & B IMMUNIZATION RECORD / WAIVER

To be completed by your health care professional, or you can waive these immunizations below.

HEPATITIS A

Immunization (Hepatitis A)

Dose #1 (Month/Day/Year): ____/____/________ Dose #2 (Month/Day/Year): ____/____/________

Immunization (Combined Hepatitis A and B vaccine)

Dose #1 (Month/Day/Year): ____/____/________ Dose #2 (Month/Day/Year): ____/____/________

Dose #3 (Month/Day/Year): ____/____/________

HEPATITIS B

Three doses of vaccine or two doses of adult vaccine in adolescents 11 to 15 years of age, or a positive hepatitis B surface antibody meets the requirement.

Immunization (Hepatitis B)

Dose #1 (Month/Day/Year): ____/____/________ □ Adult formulation □ Child formulation

Dose #2 (Month/Day/Year): ____/____/________ □ Adult formulation □ Child formulation

Dose #3 (Month/Day/Year): ____/____/________ □ Adult formulation □ Child formulation

Immunization (Combined Hepatitis A and B vaccine)

Dose #1 (Month/Day/Year): ____/____/________ Dose #2 (Month/Day/Year): ____/____/________

Dose #3 (Month/Day/Year): ____/____/________

Hepatitis B Surface Antibody

Date (Month/Day/Year): ____/____/________ Result: □ reactive □ non-reactive

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OR COMPLETE THIS SECTION:

WAIVER OF IMMUNIZATION

Although not required, it is prudent for a college student to be fully immunized for Hepatitis A and B. Students who do not receive the Hepatitis A and/or B vaccination are required to complete the waiver portion of this form.

Centers for Disease Control and Prevention (CDC) Information on Hepatitis A: http://www.cdc.gov/hepatitis/hav/
CDC Information on Hepatitis B: http://www.cdc.gov/hepatitis/hbv/

□ I choose not to be vaccinated against Hepatitis A.

□ I choose not to be vaccinated against Hepatitis B.

Print Student Name: ____

Student Signature: ____ Date: ____/____/________

Parent/Guardian Signature of Minor Student: ________________________________ Date: ____/____/________

PRE-ENROLLMENT HEALTH RECORD (Continued)

MENINGOCOCCAL DISEASE IMMUNIZATION RECORD / WAIVER

To be completed by your health care professional. (A, C, Y, W-135) One or 2 doses for all students; revaccinate every 5 years if increased risk continues. Or, you can waive this immunization below.

Quadrivalent Conjugate (preferred; administer simultaneously with Tdap if possible)

Dose #1 (Month/Day/Year): ____/____/________ Dose #2 (Month/Day/Year): ____/____/________

Quadrivalent Polysaccharide (acceptable alternative if conjugate not available)

Dose #1 (Month/Day/Year): ____/____/________

OR COMPLETE THIS SECTION:

WAIVER OF IMMUNIZATION

California law requires that colleges and universities make an increased effort to educate students about the risk of meningococcal disease or "meningitis." Although the incidence of meningitis is relatively rare, although once case per 100,000 persons per year, recent studies done by the Centers for Disease Control and Prevention (CDC) and the American College Health Association found that the **cases of meningococcal disease are three to four times higher among college freshmen that live in dormitories**. The meningococcal vaccine is effective against the four kinds of bacteria that cause about two-thirds of meningococcal disease in the United States.

The law permits a student, or if the student is a minor the student's parent or legal representative, to sign a waiver stating that s/he has received and reviewed information on meningococcal disease, risks associated with the disease, on the availability and effectiveness of any vaccine, and has chosen not to be, or not to have the student, vaccinated.

CDC Information on Meningitis: http://www.cdc.gov/meningitis/index.html
CDC Information on the Meningococcal Vaccine: http://www.cdc.gov/vaccines/vpd-vac/mening/

□ I have read the meningococcal information from the CDC and/or have discussed it with my health care provider. I choose not to be vaccinated against meningococcal disease.

Print Student Name: ____

Student Signature: ____ Date: ____/____/________

Parent/Guardian Signature of Minor Student: ________________________________ Date: ____/____/________

PRE-ENROLLMENT HEALTH RECORD (Continued)

STUDENT SIGNATURE

My signature below indicates that the information provided within the *Pre-Enrollment Health Packet* is accurate and complete, and that all immunizations and required screenings/tests have been correctly and truthfully recorded.

Student Signature: ____ Date: ____/____/________

Parent / Legal Guardian Signature: ____ Date: ____/____/________
(If a minor student, under the age of 18)

HEALTH CARE PROVIDER INFORMATION

If you have attached copies of official immunization records from your healthcare professional you may skip this section. If you attach a copy of your immunization record, please ensure that, at the minimum, it covers the required immunizations on Page 3.

Name of Healthcare Provider: ____ Certification: □ MD □ NP □ PA □ RN

Address: ____

City, State, Zip, Country: ____ Telephone: _______________________

I certify that the information contained on the *Pre-Enrollment Health Record* (pages 3 to 9) is complete and accurate to the best of my knowledge.

Health Care Provider Signature: ____ Date: ____/____/________

Your completed Pre-Entrance Health Packet [Pages 3, 4, 5, 6, 7, 8, and 9]
must be submitted to the Office of Student Affairs by July 14, 2017.
(or December 15, 2017 for Spring Semester enrollment)

Office of Student Affairs
San Francisco Conservatory of Music
50 Oak Street
San Francisco, CA 94102
or Secure Fax: 1-888-425-7426