



Date Entering
 _____/_____
 Month Year

PLEASE FAX OR MAIL REQUIRED INFORMATION TO
 YOUR SUMMER PROGRAM

IMMUNIZATION AND PHYSICAL FORM 2017

Student Information

Student Name _____
Last First Middle
 Date of Birth _____ Boston University ID Number _____
Month Day Year
 Summer Program _____ Active Email Address _____

Emergency Contact

Alternate Emergency Contact

 Name and relationship of contact

 Street Address

 City State Zip

 Contact Phone Number

 Name and relationship of contact

 Street Address

 City State Zip

 Contact Phone Number

For comprehensive information about Student Health Services including hours and directions, please visit our website at:
www.bu.edu/shs

Consents and acknowledgements

I hereby authorize the clinical staff at Boston University Student Health Services to examine and treat me during my enrollment at Boston University. _____
Initial

I consent to authorize emergency and non-emergency medical care to be provided to my child in the event of a health problem, emergency or injury occurring during my child's attendance at, or participation in, the Summer Program. I give my consent and authorization to the Program Director or his/her designee to use his/her judgment in seeking medical care for my child. I understand that an attempt will be made to contact me in the event that emergency medical care is needed. _____
Initial

I understand that there is a copay to see a provider at Boston University Student Health Services for each appointment. I understand that I am responsible for miscellaneous charges including, but not limited to, lab tests, allergy injections, immunizations, and some supplies. I understand that I am responsible for all health care charges outside of Student Health Services except that which is covered by my health insurance. _____
Initial

I understand that some costs outside of Student Health Services may not be covered by my medical insurance. _____
Initial

I understand that Student Health Services is a unit inclusive of medical, mental health, nutrition, sports medicine, and alcohol and other drug services. I understand that the providers within this organization may discuss my care within the unit to allow for effective care delivery and care management. _____
Initial

I understand that some services provided are limited by staff and space availability. While we may endeavor to serve all students eligible for care, there may be circumstances when referral to outside providers in the community is necessary. _____
Initial

The information on this form is for the use of Student Health Services and will not be released to a third party without your consent, except as necessary to fulfill the responsibilities of Student Health Services or as required by law. _____
Initial

 Student Signature Date

 Parent/guardian signature Parent/guardian name (please print) Date Relationship to Student

(Must be signed by a parent or guardian if student is under 18 years of age)

Important Immunization Information, Please Read Carefully

Massachusetts State Immunization Requirements

These **must** be completed **prior** to coming to campus.

1. A booster of tetanus, diphtheria and pertussis (Tdap) within the last 10 years.
2. Two MMR (measles, mumps and rubella) shots or blood tests indicating immunity to these conditions. The first shot must be given AFTER 12 months of age.
3. Three doses of hepatitis B vaccine (or appropriately timed 2 dose series) or a blood test indicating immunity to hepatitis B.
4. One dose of meningitis vaccine for students who will be living on campus. Must be administered within the last 5 years.
5. A medical provider certified history of chicken pox or two doses of chicken pox vaccine given 4-8 weeks apart or a blood test indicating immunity to chick pox.
6. Please see the directions on Page 4 pertaining to all the requirements for tuberculosis.

The MONTH, DAY, and YEAR of the immunization must be provided by the physician

Such statements as “received as a child”, “records were lost” or “up to date” are NOT acceptable.

All immunization records must be signed by an MD/NP/PA or be copies of original immunization records.

The only circumstances under which a student may be exempt from submitting proof of immunizations are as follows:

- A physician certifies that a medical condition precludes immunization.
- The student states in writing that the required immunizations would conflict with his/her religious beliefs.

For students who have not received the required vaccines and in the event of a campus infectious disease exposure or outbreak, the student may be required to leave campus during the period of contagion.

This sheet is for your information and does not need to be sent back to Student Health Services.



Information about Meningococcal for Students at Residential Schools and

Disease and Vaccination and Waiver Colleges

PLEASE NOTE: BOSTON UNIVERSITY STUDENT HEALTH SERVICES RECOMMENDS AGAINST WAIVING THIS IMPORTANT VACCINE.

Revised legislation in Massachusetts now requires all newly enrolled full-time students attending a secondary school (e.g., boarding schools) or postsecondary institution (e.g., colleges) who will be living in a dormitory or other congregate housing licensed or approved by the secondary school or institution to:

1. receive meningococcal vaccine; or
2. fall within one of the exemptions in the law, which are discussed on the reverse side of this sheet.

The law provides an exemption for students signing a waiver that reviews the dangers of meningococcal disease and indicates that the vaccination has been declined. To qualify for this exemption, you are required to review the information below and sign the waiver at the end of this document. Please note, if a student is under 18 years of age, a parent or legal guardian must be given a copy of this document and must sign the waiver.

What is meningococcal disease?

Meningococcal disease is caused by infection with bacteria called *Neisseria meningitidis*. These bacteria can infect the tissue that surrounds the brain and spinal cord called the “meninges” and cause meningitis, or they can infect the blood or other body organs. In the United States, about 2,600 people each year get meningococcal disease and 10-15% die despite receiving antibiotic treatment. Of those who live, another 11-19% lose their arms or legs, become deaf, have problems with their nervous systems, become mentally retarded, or suffer seizures or strokes.

How is meningococcal disease spread?

These bacteria are passed from person-to-person through saliva (spit). You must be in close contact with an infected person’s saliva in order for the bacteria to spread. Close contact includes activities such as kissing, sharing water bottles, sharing eating/drinking utensils or sharing cigarettes with someone who is infected; or being within 3-6 feet of someone who is infected and is coughing or sneezing.

Who is at most risk for getting meningococcal disease?

People who travel to certain parts of the world where the disease is very common are at risk, as are military recruits who live in close quarters. Children and adults with damaged or removed spleens or an inherited disorder called “terminal complement component deficiency” are at higher risk. People who live in settings such as college dormitories are also at greater risk of infection.

Are some students in college and secondary schools at risk for meningococcal disease?

College freshmen living in residence halls or dormitories are at an increased risk for meningococcal disease as compared to individuals of the same age not attending college. The setting, combined with risk behaviors (such as alcohol consumption, exposure to cigarette smoke, sharing food or beverages, and activities involving the exchange of saliva), may be what puts college students at a greater risk for infection. There is insufficient information about whether new students in other congregate living situations (e.g., residential schools) may also be at increased risk for meningococcal disease. But, the similarity in their environments and some behaviors may increase their risk.

The risk of meningococcal disease for other college students, in particular older students and students who do not live in congregate housing, is not increased. However, meningococcal vaccine is a safe and efficacious way to reduce their risk of contracting this disease.

Is there a vaccine against meningococcal disease?

Yes, there are currently 2 vaccines available that protect against 4 of the most common of the 13 serogroups (subgroups) of *N. meningitidis* that cause serious disease. Meningococcal polysaccharide vaccine is approved for use in those 2 years of age and older and meningococcal conjugate vaccine is approved for use in those 11-55 years of age. Both types of meningococcal vaccines are acceptable for college students and residential school students 11 years of age and older. For those younger than 11 years of age, meningococcal polysaccharide vaccine is the only licensed vaccine. Both of the vaccines provide protection against four serogroups of the bacteria, called groups A, C, Y and W-135. These four serogroups account for approximately two-thirds of the cases that occur in the U.S. each year. Most of the remaining one-third of the cases are caused by serogroup B, which is not contained in the vaccine. Protection from immunization with the meningococcal polysaccharide vaccine is not lifelong; it lasts about 3 to 5 years in healthy adults (some people may be protected longer.) The meningococcal conjugate vaccine is expected to help decrease disease transmission and provide more long-term protection.

Is the meningococcal vaccine safe?

A vaccine, like any medicine, is capable of causing serious problems such as severe allergic reactions. The risks associated with receiving the vaccine are much less significant than the risks that would arise in a case of meningococcal disease. Getting meningococcal vaccine is much safer than getting the disease. Some people who get meningococcal vaccine have mild side effects, such as redness or pain where the shot was given. These symptoms usually last for 1-2 days. A small percentage of people who receive the vaccine develop a fever. The vaccine can be given to pregnant women.

A few cases of Guillain-Barré syndrome (GBS), a rare but serious nervous system disorder, have been reported among people who received meningococcal conjugate vaccine. This information is still being evaluated by health officials. An ongoing risk of serious meningococcal disease exists. At this time, experts continue to recommend vaccination for those at increased risk of acquiring meningococcal disease. However, persons who have had GBS should generally not receive meningococcal conjugate vaccine, and should talk to their doctor about their other options for vaccination.

Is it mandatory for students to receive meningococcal vaccine for entry into secondary schools or colleges that provide or license housing?

Massachusetts law (MGL Ch. 76, s.15D) requires newly enrolled full-time students attending a secondary school (those schools with grades 9-12) or postsecondary institution (e.g., colleges) who will be living in a dormitory or other congregate housing licensed or approved by the secondary school or institution to receive meningococcal vaccine. At affected secondary schools, the requirements apply to all new full-time residential students, regardless of grade (including grades pre-K through 8) and year of study. All students covered by the regulations must provide documentation of having received a dose of meningococcal polysaccharide vaccine within the last 5 years (or a dose of meningococcal conjugate vaccine at any time in the past), unless they qualify for one of the exemptions allowed by the law. Whenever possible, immunizations should be obtained prior to enrollment or registration. However, students may be enrolled or registered provided that the required immunizations are obtained within 30 days of registration.

Students may begin classes without a certificate of immunization against meningococcal disease if: 1) the student has a letter from a physician stating that there is a medical reason why he/she can't receive the vaccine; 2) the student (or the student's parent or legal guardian, if the student is a minor) presents a statement in writing that such vaccination is against his/her sincere religious belief; or 3) the student (or the student's parent or legal guardian, if the student is a minor) signs the waiver below stating that the student has received information about the dangers of meningococcal disease, reviewed the information provided and: a) elected to decline the vaccine; or b) could not obtain meningococcal vaccine due to a shortage, but wishes to receive vaccine (as indicated below).

Where can a student get vaccinated?

Students and their parents should contact their healthcare provider and make an appointment to discuss meningococcal disease, the benefits and risks of vaccination, and the availability of this vaccine. Schools and college health services are not required to provide you with this vaccine.

Where can I get more information?

- Your healthcare provider
- The Massachusetts Department of Public Health, Division of Epidemiology and Immunization at (617) 983-6800 or www.mass.gov/dph
- Your local health department (listed in the phone book under government)

Waiver for Meningococcal Vaccination Requirement

I have received and reviewed the information provided on the risks of meningococcal disease and the risks and benefits of meningococcal vaccine. I understand that Massachusetts' law requires newly enrolled full-time students at secondary schools, colleges and universities who are living in a dormitory or congregate living arrangement licensed or approved by the secondary school or postsecondary institution to receive meningococcal vaccinations, unless the students provide a signed waiver of the vaccination or otherwise qualify for one of the exemptions specified in the law.

Please check the appropriate box below.

After reviewing the materials above on the dangers of meningococcal disease, I choose to waive receipt of meningococcal vaccine.

-OR-

Due to the shortage of meningococcal vaccine, I was unable to be vaccinated, but wish to receive vaccine.

Student Name: _____ Date of Birth: _____

Student BU ID: _____

Signature: _____ Date: _____

(Student or parent/legal guardian, if student is under 18 years of age)

Required Immunization RecordMust be signed by **MD/NP/PA** and must include **MM/DD/YYYY**Must be completed **PRIOR** to arrival at Boston University

Vaccines	Dates Given	Massachusetts State Requirements
MMR	#1 ___/___/___ MM DD YYYY Oldest	<ul style="list-style-type: none"> 2 doses of MMR Minimum of 4 weeks between doses OR <ul style="list-style-type: none"> 2 doses of each individual component (2 measles, 2 mumps, and 2 rubella) Minimum of 4 weeks between doses OR <ul style="list-style-type: none"> Positive titers
OR	#2 ___/___/___ MM DD YYYY Newest	
Individual Vaccines: Measles Mumps Rubella	Measles #1 ___/___/___ MM DD YYYY Oldest	
	#2 ___/___/___ MM DD YYYY Newest	
	Mumps #1 ___/___/___ MM DD YYYY Oldest	
	#2 ___/___/___ MM DD YYYY Newest	The first dose given MUST be received after your 1st birthday
	Rubella #1 ___/___/___ MM DD YYYY Oldest	
	#2 ___/___/___ MM DD YYYY Newest	
OR	Measles Titer Date: ___/___/___ MM DD YYYY	
Positive Titers	Mumps Titer Date: ___/___/___ MM DD YYYY	
	Rubella Titer Date: ___/___/___ MM DD YYYY	
Tdap	___/___/___ (Td shot is NOT acceptable, must be Tdap) MM DD YYYY	Tdap (Tetanus, Diphtheria & Pertussis) is the only acceptable form of Tetanus shot. This must be within 10 years.
Meningitis	___/___/___ MM DD YYYY	Menomune OR Menactra OR Waiver <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		One dose for incoming students living on campus within 5 years or a completed waiver signed on Page 4
Hepatitis B	#1 ___/___/___ MM DD YYYY Oldest	Completed 3 part series
	#2 ___/___/___ MM DD YYYY	
	#3 ___/___/___ MM DD YYYY Newest	
OR		
Titer	Hepatitis B Positive Titer Date ___/___/___ MM DD YYYY	Positive titer
Varicella	#1 ___/___/___ MM DD YYYY Oldest	2 doses of varicella vaccine
	#2 ___/___/___ MM DD YYYY Newest	
OR		
Titer	Varicella Positive Titer Date ___/___/___ MM DD YYYY	Positive titer
OR		
Disease	Date of Disease ___/___/___ MM DD YYYY	History of disease must be verified by a medical provider with the MM/DD/YYYY

Last Name

Date of birth

BU ID Number

Tuberculosis Record
Must be signed by MD/NP/PA
Must be completed PRIOR to arrival at Boston University

- | | | |
|--|------------|-----------|
| 1. Have you had a positive TB skin test in the past? | Yes | No |
| 2. To the best of your knowledge, have you had close contact with anyone who was sick with tuberculosis? | Yes | No |
| 3. Were you born in one of the countries listed below? | Yes | No |
| 4. Have you travelled or lived for more than one month in any of the countries listed below? | Yes | No |
| 5. Have you completed 6-9 months of medication (i.e. isoniazid) to prevent active tuberculosis (tuberculosis prophylaxis)? | Yes | No |

If you have a history of a positive tuberculosis skin test and have never taken medication to prevent active tuberculosis, please report to Student Health Services on arrival to campus to discuss this treatment.

If you answered **YES to number 2, 3, or 4**, you need to provide documentation of a recent tuberculosis skin test (TST) administered within the past year

Tuberculosis skin test date _____ **Result** _____ mm **Interpretation (check one) Pos** **Neg**

If a current or past tuberculosis skin test is/was positive, you will need to complete the following evaluation/treatment.

Chest x-ray date _____ **Result (check one) Pos** **Neg**

Treatment:

Yes _____
(Drug, Dose, Frequency, and Dates)

No _____
(Please document reason prophylaxis or treatment not done)

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

Clinician name MD/NP/PA (please print)

Signature

Date

Last Name

Date of birth

BU ID Number

HEALTH HISTORY
Must be signed by MD/NP/PA

1. List any significant past medical, surgical or mental health conditions including hospitalizations. Use additional pages if necessary.

None

2. List all ongoing medications or treatments with dosages/directions and briefly describe what each medication is treating

None

Medication, dose, directions	Condition addressed by this medication

3. List all environmental or medical allergies. None

4. Note any pertinent family history. None

5. List all pertinent physical exam findings. PE within normal limits Abnormal findings as follows

Date of most recent physical exam (requested from students, but not mandatory): ____/____/____
This student has been evaluated to be in good health and able to participate in highly competitive athletics, if they choose to do so: Yes No. Please explain below:

Clinician name MD/NP/PA (please print)

Signature

Date