Boston University
Student Health Services
881 Commonwealth Ave, West
Boston, MA 02215
Phone: (617)353-3575
Fax: (617)353-3557
(617)353-7224

Date Entering

_____/_____
Month Year

FORM IS DUE AUG. 1st FOR FALL MATRICULATION.
PLEASE FAX OR MAIL REQUIRED INFORMATION

Immunization and Physical Form 2012

Student Information
(To be completed by the student)

Student Name _____
Last First Middle

Date of Birth _____ Boston University ID or Social Security Number_____
Month Day Year

Active Email Address _____

By what pronoun do you prefer to be called (he, she, ze)_____

School, College, or Program at BU: _____ (MED and Dental, please use Medical Campus Form)
For example: "Engineering"

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

Meningococcal Waiver is **ONLY** if you plan on waiving the requirement for the Meningococcal Vaccine. If you have received the vaccine, please ignore the waiver and proceed to the next page.

Waiver for Meningococcal Vaccination Requirement

I have received and reviewed the Meningococcal Information Form provided on the risks of meningococcal disease and the risks and benefits of meningococcal vaccine (available at www.bu.edu/shs/forms). 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 ID or SSN: _____

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

Last Name | Date of birth | BU ID or Social Security Number

Required Immunization Record

Must be signed by MD/NP/PA
Must be completed PRIOR to arrival at Boston University
Must include Month/Day/Year

Please read our Immunization Information Form regarding all required immunizations here at www.bu.edu/shs/forms.

Vaccines	Dates Given	Massachusetts State Requirements
MMR	#1____/____/____ (Month Day Year) #2____/____/____ (Month Day Year)	2 doses of MMR (measles, mumps and rubella) Minimum of 4 weeks between doses **#1 given after 1st birthday**
OR		**OR**
Measles	Positive Titer Date ____/____/____ (Month Day Year)	Positive titers
Mumps	Positive Titer Date ____/____/____ (Month Day Year)	
Rubella	Positive Titer Date ____/____/____ (Month Day Year)	
Tdap (Tetanus, Diphtheria & Pertussis)	____/____/____ (Month Day Year)	Tdap is the only acceptable form of Tetanus shot. Tdap booster within the last 10 years
Meningitis	____/____/____ (Month Day Year) Memomune ☐ OR Menactra ☐ OR Waiver ☐	One dose for incoming students living on campus within 5 years or completed waiver (page 1)
Hepatitis B (3 Part Series)	#1____/____/____ #2____/____/____ #3____/____/____ (Month Day Year)	Completed 3 part series
OR		**OR**
Hepatitis B (2 Part Series)	#1____/____/____ #2____/____/____ (Month Day Year)	Completed 2 part series (For 2 part series: Between ages 11 and 15 only, 1cc.)
OR		**OR**
Hepatitis B (Titer)	Positive Titer Date ____/____/____ (Month Day Year)	Positive titer
Varicella	#1____/____/____ #2____/____/____ (Month Day Year)	2 doses of varicella vaccine
OR		**OR**
Varicella (Titer)	Positive Titer Date ____/____/____ (Month Day Year)	Positive titer
OR		**OR**
Chicken Pox	Date of Disease ____/____/____ (Month Day Year)	History of disease History of disease must be verified by a medical provider

Clinician name MD/NP/PA (please print) | Signature | State license number | Date

Last Name _____ Date of birth _____ BU ID or Social Security Number _____

Required Physical Information

Must be signed by MD/NP/PA
Must include Month/Day/Year

Date of physical exam (must be within one year of matriculation): _____/_____/_____
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 State license number Date

Optional Immunization Record

Must be signed by MD/NP/PA
Must include Month/Day/Year

Vaccines	Dates Given	Massachusetts States Recommendations
Influenza	____/____/____ Month Day Year	One injection every year.
Polio	#1____/____/____ Month Day Year #2____/____/____ Month Day Year	People traveling to areas of the world where polio is common should consider an additional 1-2 doses of injected polio vaccine, depending on completion of the primary vaccine series.
Hepatitis A	#1____/____/____ Month Day Year #2____/____/____ Month Day Year	The two injections should be given 6 months apart from one another.
Typhoid	____/____/____ Month Day Year Injection OR ____/____/____ Month Day Year Oral Vaccine	The injection lasts for 2 years. The oral vaccine lasts 5 years.
Yellow Fever	____/____/____ Month Day Year	One injection lasts for 10 years.
TwinRix (Combination Hep A and Hep B)	#1____/____/____ Month Day Year #2____/____/____ Month Day Year #3____/____/____ Month Day Year	Three doses over a course of six months.
Human Papillomavirus	#1____/____/____ Month Day Year #2____/____/____ Month Day Year #3____/____/____ Month Day Year	1st dose to be followed by 2nd dose after 2 months followed by 3rd dose 6 months after 1st dose.

Clinician name MD/NP/PA (please print) Signature State license number Date

Last Name _____ Date of birth _____ BU ID or Social Security 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 you previously received BCG vaccine, a blood test such as Quantiferon Gold or T-Spot is the preferred test to indicate absence of TB.
Date_____ Result (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	Lativia	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 State license number Date