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 PRIOR TO MATRICULATION
PLEASE FAX OR MAIL REQUIRED INFORMATION

IMMUNIZATION AND PHYSICAL FORM 2015

Student Information
(To be completed by the student)

Student Name _____
Last First Middle

Date of Birth _____ Boston University ID # _____
Month Day Year

Active Email Address _____

School, College, or Program at BU: _____
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 Form regarding all required immunizations here at www.bu/shs/forms

Vaccines	Dates Given	Massachusetts State Requirements
MMR	Oldest #1___ / ___ / ___ (MM DD YYYY) Newest #2___ / ___ / ___ (MM DD YYYY)	• 2 doses of MMR • Minimum of 4 weeks between doses • 1st dose given **after 1st birthday**
OR		**OR**
Individual Vaccines: Measles Mumps Rubella	**Measles** Oldest #1___ / ___ / ___ Newest #2___ / ___ / ___ (MM DD YYYY) **Mumps** Oldest #1___ / ___ / ___ Newest #2___ / ___ / ___ (MM DD YYYY) **Rubella** Oldest #1___ / ___ / ___ Newest #2___ / ___ / ___ (MM DD YYYY)	• 2 doses of each individual component (2 measles, 2 mumps, and 2 rubella) • Minimum of 4 weeks between doses • 1st dose given **after 1st birthday**
OR		**OR**
Positive Titers	Measles Titer Date: ____/____/____ (MM DD YYYY) Mumps Titer Date : ____/____/____ (MM DD YYYY) Rubella Titer Date : ____/____/____ (MM DD YYYY)	Positive Titers
Tdap	___ / ___ / ___ (MM DD YYYY)	**Tdap** (Tetanus, Diphtheria & Pertussis) **is the only acceptable form of Tetanus shot** (Must be within last 10 years)
Meningitis	____/____/____ (MM DD YYYY) Menomune ☐ OR Menactra ☐ OR Waiver ☐	One dose for incoming students living on campus within 5 years or completed waiver (page 1)
Hepatitis B	Oldest #1___ / ___ / ___ #2___ / ___ / ___ #3 ___ / ___ / ___ Newest (MM DD YYYY)	Completed 3 part series
OR		**OR**
Positive Titer	Hepatitis B Titer Date ____/____/____ (MM DD YYYY)	Positive titer
Varicella	Oldest #1___ / ___ / ___ Newest #2___ / ___ / ___ (MM DD YYYY)	2 doses of varicella vaccine
OR		**OR**
Titer	Positive Titer Date ____/____/____ (MM DD YYYY)	Positive titer
OR		**OR**
Disease	Date of Disease ____/____/____ (MM DD YYYY)	History of disease must be verified by a medical provider

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

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

- All clinical students are required to have **TWO** negative Tuberculosis Skin Tests (TST) **PRIOR** to arriving at school. The tests must be completed within 6 months of matriculation and are ideally spaced 1-2 weeks apart. This will prevent you from participating in classes if unresolved upon arrival. Students who do not have access to a TST in their country can have the TST test(s) done at Student Health Services.
- This is required of all clinical students regardless of the following previous conditions: testing outside of the 6 month time frame, BCG vaccination history, chest x-rays, or blood testing (QuantiFERON Gold or T-Spot).
- Please Note: If you have had a positive tuberculin skin test in the past, you do not need another test, however we do need information regarding the positive test, chest x-ray results, and clinical evaluation filled out on the lower half of this page. Clinical evaluation must be within one year of matriculation date.

Negative Tuberculosis Skin Test	**Plant Date**	**Read Date** (Must be within 48-72 hours of plant)	**MM**	2 tuberculosis skin tests within 6 months of matriculation spaced 1-2 weeks apart
Most recent TST (must be within 6 months)	____/____/____	____/____/____		
Second most recent TST	____/____/____	____/____/____		

Only In The Case Of A Positive Skin Test, Complete The Following:

Positive Skin Test
Date Planted ____/____/____

Date Read ____/____/____

Result in MM of induration _____ MM

Have you ever had a BCG vaccine? Yes / No

If yes, what was the date of the vaccine? ____/____/____

Because the Tuberculosis Skin Test is Positive, you will need to complete the following evaluation/treatment:

Chest X-Ray Date: ____/____/____

☐ Normal or ☐ Abnormal:_____
(Describe)

Clinical Evaluation Date ____/____/____ (Must be within 1 year of matriculation date)

☐ Normal (Absence of cough, hemoptysis, fevers, chills, sweats, weight loss)

☐ Abnormal: _____
(Describe)

Treatment

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

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

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

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

Recommended 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 is 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

Optional Immunization Record

These are Not Required
Must be signed by MD/NP/PA
Must include Month/Day/Year

Vaccines	Dates Given	Massachusetts States Recommendations
Influenza	____/____/____ MM DD YYYY	One injection every year.
Polio	Oldest #1___ / ___ / ___ MM DD YYYY Newest #2___ / ___ / ___ MM DD YYYY	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	Oldest #1___ / ___ / ___ MM DD YYYY Newest #2___ / ___ / ___ MM DD YYYY	The two injections should be given 6 months apart from one another.
Typhoid	____/____/____ MM DD YYYY Injection OR ____/____/____ MM DD YYYY Oral Vaccine	The injection lasts for 2 years. The oral vaccine lasts 5 years.
Yellow Fever	____/____/____ MM DD YYYY	One injection lasts for 10 years.
TwinRix (Combination Hep A and Hep B)	Oldest #1___ / ___ / ___ MM DD YYYY #2___ / ___ / ___ MM DD YYYY Newest #3 ___ / ___ / ___ MM DD YYYY	Three doses over a course of six months.
Human Papilloma Virus	Oldest #1___ / ___ / ___ MM DD YYYY #2___ / ___ / ___ MM DD YYYY Newest #3 ___ / ___ / ___ MM DD YYYY	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 | Date