

**Boston University**  
**Student Health Services**  
881 Commonwealth Avenue  
Boston, Massachusetts 02215  
(617) 353-3575  
Fax: (617) 353-7224  
(617) 353-3557



<b>Date Entering</b>	
____/____/____	
Month	Year

**FORM MUST BE COMPLETED IN ENGLISH**

**HEALTH HISTORY AND PHYSICAL EXAMINATION REPORT (CLINICAL)**

\*The information requested on this form is for the use of Student Health Services and will not be released to anyone without your knowledge and consent, except as necessary to fulfill the responsibilities of Student Health Services, or as required by law.

**Mandatory Form - Must Be Completed In Order To Begin Study At Boston University**

<b>Student Information</b> <i>(to be completed by student)</i>			
<b>Student Name</b>			
_____	_____	_____	_____
Last	First	Middle	
<b>School:</b> SCHOOL OF DENTAL MEDICINE			
<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>Date of Birth</b> _____/_____/_____	
		Month	Day
<b>Boston University Identification# (BU ID#) or SS#</b> _____			
<b>Permanent Address</b>			
Number and street _____			
City _____		State _____ Zip code _____	
Country _____			
<b>Telephone</b> _____		<b>E-mail</b> _____	
<b>Permanent Emergency Contact</b>		<b>Alternate Emergency Contact</b>	
Name and relationship of person to be notified _____		Name and relationship of person to be notified _____	
Number and street _____		Number and street _____	
City _____ State _____ Zip _____		City _____ State _____ Zip _____	
Best contact telephone number _____		Best contact telephone number _____	
<b>Do you plan to purchase medical insurance available through Boston University?</b>			
[ ] Yes [ ] No <i>(If No, attach a copy of your insurance card, both front and back sides and complete the waiver online.)</i>			
<b>Consent for Treatment</b>			
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 understand that there is no charge to see a provider at Boston University Student Health Services. However, I understand that I am responsible for miscellaneous charges including but not limited to lab tests, allergy injections, immunizations, some medications and splinting materials. I understand that I am responsible for all 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 have received a copy of Student Health Services Notice of Privacy Practices (enclosed with this form). _____ Initial			
Student Signature _____		Date _____	
<i>(Must be signed by a parent or guardian if student is under 18 years of age.)</i>			
Parent/Guardian name (please print) _____		Signature _____	
		Date _____	
		Relationship _____	



Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Date of Birth (MM/DD/YYYY) \_\_\_\_\_

B.U. ID or SS# \_\_\_\_\_

**HEALTH STATEMENT (To be completed by MD/NP/PA)**

1. List any significant past or current medical, surgical, or mental health conditions, including hospitalizations (use additional pages if necessary).  None

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. List all ongoing treatments/medications with dosages/directions.  None

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. List all medical or environmental allergies.  None

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Note any pertinent family history.  None

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. List all pertinent physical exam findings.  PE Within Normal Limits  Abnormal Findings as follows

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Date of Physical Exam (must be within One Year of Matriculation): \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_

**Clinician's Signature**

MD/NP/PA Name (Please Print) \_\_\_\_\_ Signature \_\_\_\_\_ State License \_\_\_\_\_ Date \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone \_\_\_\_\_

## BOSTON UNIVERSITY IMMUNIZATION REQUIREMENTS

Boston University requires that the following be completed PRIOR to coming to campus:

1. A booster dose of tetanus, diphtheria, acellular pertussis (Tdap) within the last 10 years.
2. Two MMR (measles, mumps and rubella) shots after 12 months of age.
3. Three doses of hepatitis B vaccine and a Hepatitis B surface antibody titer for students who have completed Hepatitis B vaccine.
4. One dose of meningitis vaccine in the last 5 years for incoming students living in residence halls.
5. A provider certified history of having had varicella (chicken pox) or two doses of varicella live vaccine, 4-8 weeks apart or serological proof of immunity.
6. A two-step tuberculin skin test. Step 2 must be 1-2 weeks after Step 1 and both must be within 6 months of matriculation. If Positive, a chest X-ray, provider clinical evaluation and provider documentation of discussion of TB prophylaxis.
7. Month and year of immunization must be provided. If the vaccine was given at 12 months of age, the month, day, and year are required.
8. Such statements as "received as a child," "records were lost," or "up to date" are not acceptable.
9. All immunization records must be signed by a physician or designee. **Records signed by parents are not acceptable.**

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

- a. Certification in writing by an examining physician who is of the opinion that the physical condition is such that health would be endangered by one or more of the immunizations.
- b. The student states in writing that the required immunizations would conflict with his/her religious beliefs.
- c. In the case of measles, mumps, rubella, and hepatitis B, the student presents laboratory evidence of immunity.

*In the event of an exposure to an infectious disease for which the student has been exempted from proof of immunization or immunity, the student may be required to leave campus during the period of time in which the student may be contagious.*



Last Name First Name M.I.

Date of Birth (MM/DD/YYYY)

B.U. ID or SS#

BOSTON UNIVERSITY IMMUNIZATION FORM

The record of immunizations and screening procedures must be up to date and received at the address on the following page in order for you to matriculate at Boston University.

Immunization Vaccine/Date Titer/Date
MMR Vaccine
MMR no. 1
MMR no. 2
or
Measles titer
Mumps titer
Rubella titer
Tetanus Vaccine (Tdap)
Hepatitis B no. 1 and
Hepatitis B no. 2
Hepatitis B no. 3
Meningococcal Vaccine
Menactra (MCV4)\*
or
Menimmune (MPSVA4)
or Waiver (Page 8 of this form)
Varicella (Chicken Pox)
Date of Disease
or
Varicella 1 and Varicella 2
or
Varicella antibody titer

MD/NP/PA Name (please print) Signature State License Date



Last Name	First Name	M.I.
Date of Birth (MM/DD/YYYY)		
B.U. ID OR SS#		

We at Student Health Services recognize that the educational experience you are undertaking will be both exciting and stressful. We want you to know that Behavioral Medicine at Student Health Services offers free evaluations, short term counseling and medication to help you if you find that you are feeling anxious, depressed, or overwhelmed with your experience.

The following are some questions about your emotional and mental health. The responses are completely confidential and are solely for the purpose of providing excellent service to students. You may opt not to answer these questions.

1. Have you ever been cared for by a mental health clinician?  Yes  No
  
2. Have you ever been hospitalized for a mental health problem?  Yes  No
  
3. Have you been on medication at any time for an emotionally-related problem such as depression, anxiety, mania (mind racing)?  Yes  No

**Mental Health Resources**

- |   |                    |
|---|--------------------|
| Boston University Student Health Services<br>Behavioral Medicine Department | (617) 353-3569     |
| <br>The Danielsen Institute   | <br>(617) 353-3047 |
| <br>The Center for Anxiety and Related Disorders                            | <br>(617) 353-9610 |
| <br>Psychological Services Center   | <br>(617) 358-4290 |



Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Date of Birth (MM/DD/YYYY) \_\_\_\_\_

B.U. ID OR SS# \_\_\_\_\_

### TWO STEP TUBERCULOSIS SKIN TESTING

Please note: If you have had a positive tuberculin skin test in the past, you do not need another test. However, we need the date and result of your positive skin test. If your skin test is positive, you must have a chest xray and clinical evaluation.

#### TUBERCULIN SKIN TEST (STEP 1)

*Note: Use 5 TU Mantoux test (intermediate PPD) only; result of multiple puncture tests, such as Tine or Mono-vac, not accepted.*

Date: \_\_\_\_\_

Result (48-72 hours) \_\_\_\_\_ mm of induration.  
(if no induration, mark "O")

#### TUBERCULIN SKIN TEST (STEP 2) - 1 to 2 weeks after Step 1.

Date: \_\_\_\_\_

Result (48-72 hours) \_\_\_\_\_ mm of induration.  
(if no induration, mark "O")

#### IF THE TUBERCULIN SKIN TEST IS POSITIVE:

##### CHEST X-RAY

Date: \_\_\_\_\_  Normal  Abnormal \_\_\_\_\_

##### CLINICAL EVALUATION

(Describe)

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's Signature

MD/NP/PA Name (please print) \_\_\_\_\_ Signature \_\_\_\_\_ State License \_\_\_\_\_ Date \_\_\_\_\_



## **Information about Meningococcal Disease and Vaccination and Waiver for Students at Residential Schools and Colleges**

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 US, about 1,000-3,000 people get meningococcal disease each year 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 2-55 years of age. 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 either vaccine. Protection 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.

**(See reverse side)**

### Is the meningococcal vaccine safe?

A vaccine, like any medicine, is capable of causing serious problems such as severe allergic reactions. 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 elected to decline the vaccine.

### 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/imm](http://www.mass.gov/dph/imm) and <http://www.mass.gov/epi>
- Your local health department (listed in the phone book under government)

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## 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.

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