



Date Entering
/
Month Year

PLEASE FAX OR MAIL REQUIRED INFORMATION
TO YOUR SUMMER PROGRAM

IMMUNIZATION AND PHYSICAL FORM

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 _____

Name and relationship of contact _____

Street Address _____

Street Address _____

City State Zip _____

City State Zip _____

Contact Phone Number _____

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)

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 <u> / / </u> #2 <u> / / </u> MM DD YYYY MM DD YYYY Oldest Newest	<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 <p>The first dose given MUST be received after your 1st birthday</p>
OR	<p>Measles</p> #1 <u> / / </u> #2 <u> / / </u> MM DD YYYY MM DD YYYY Oldest Newest	
Individual Vaccines: Measles Mumps Rubella	<p>Mumps</p> #1 <u> / / </u> #2 <u> / / </u> MM DD YYYY MM DD YYYY Oldest Newest	
	<p>Rubella</p> #1 <u> / / </u> #2 <u> / / </u> MM DD YYYY MM DD YYYY Oldest Newest	
OR	Measles Titer Date: <u> / / </u> MM DD YYYY Mumps Titer Date: <u> / / </u> MM DD YYYY Rubella Titer Date: <u> / / </u> MM DD YYYY	
Tdap	<u> / / </u> (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.
Hepatitis B	#1 <u> / / </u> #2 <u> / / </u> #3 <u> / / </u> MM DD YYYY MM DD YYYY MM DD YYYY Oldest Newest	Completed 3 part series
OR	Hepatitis B Positive Titer Date <u> / / </u> MM DD YYYY	Positive titer
Varicella	#1 <u> / / </u> #2 <u> / / </u> MM DD YYYY MM DD YYYY Oldest Newest	2 doses of varicella vaccine
OR	Varicella Positive Titer Date <u> / / </u> MM DD YYYY	Positive titer
OR	Disease Date of Disease <u> / / </u> MM DD YYYY	History of disease must be verified by a medical provider with the MM/DD/YYYY

Meningitis Record

One dose within 5 years for all students living on campus required or a completed waiver.

Meningitis Vaccination: Menactra

____ / ____ / ____
MM DD YYYY

OR

Menomune

____ / ____ / ____
MM DD YYYY

MENINGITIS WAIVER

Meningococcal Waiver is **ONLY** if you plan on waiving the requirement for the Meningococcal Vaccine. If you have received the vaccine, please ignore this waiver.

Waiver for Meningococcal Vaccination Requirement

I have received and reviewed the Meningococcal Information Form provided on the risks of meningococcal disease and the risks & benefits of meningococcal vaccine (available at <http://www.bu.edu/shs/immunizations>) Check below:

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

Student Signature: _____ Date: _____
(Parent/Guardian signature if student is under 18 years old)

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)

Tuberculosis Record

**REQUIRED FOR ALL INTERNATIONAL STUDENTS AND DOMESTIC STUDENTS
COMPLETED BY STUDENT AND SIGNED BY HEALTH CARE PROVIDER (MD/NP/PA)**

Part A. Tuberculosis

1. Have you had a positive tuberculosis skin test in the past? **YES** (complete below) **NO** (skip to Part B)

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

Positive Skin Test: Plant Date ____/____/____ Plant Read ____/____/____ Result in MM: _____

Blood QuantiFERON Gold Test: ____/____/____ Result: Positive ____ Negative ____

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: ____/____/____

Result: Normal Abnormal (describe) _____

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

Part B. Tuberculosis

- | | | |
|---|------------|-----------|
| 1. Are you an international student? | 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 or have you travelled for extended periods of time (more than 1 month) to one of the high risk countries found here:
http://www.bu.edu/shs/immunizations | YES | NO |
| 4. Have you completed 6-9 months of medication to prevent active tuberculosis?

(i.e. isoniazid) | YES | NO |

- If you answered **YES** to **any questions** you must provide proof of a recent tuberculosis test administered within last year:

Tuberculosis Skin Test (Must be within the past year)	Plant Date ____/____/____	Read Date (within 48-72 hours of plant) ____/____/____	MM
QuantiFERON Gold Test	Date ____/____/____	Result: ____ Positive ____ Negative	

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