ATTENTION STUDENTS:

You must show proof that you have received the following shots. If you cannot get them in your country, you will be required to take them at BU Student Health Services or at another Medical Facility in the US.

MMR/Measles, Mumps, and Rubella vaccine

TDap/Tetanus vaccine

Hepatitis B vaccine

Varicella/Chicken Pox vaccine

Meningitis (only if you live on campus)

If you have either of the Boston University Student Health Insurance plans offered through AETNA Insurance, all the following shots are covered and you will NOT be charged. If you have private insurance, and take the shot(s) at Student Health Services, SHS will BILL your Student Account for the cost of the shot(s) and will give you a receipt to turn into your insurance company to seek reimbursement. Student Health Services cannot guarantee what you’re outside insurance provider will or will not cover.
YOU MUST COMPLETE THIS FORM AND UPLOAD IT TO BOSTON UNIVERSITY STUDENT HEALTH SERVICES BEFORE CLASSES BEGIN. Please complete and sign your Immunization and Physical Form in English. When your form is complete, please follow these steps to upload your form to our secure online health portal Patient Connect.

1. Take a picture of your completed forms or scan them to your computer. There should be one picture for each page that has been filled out. If you have questions, please contact CELOP Admissions (celop@bu.edu).

2. Go to bu.edu/patientconnect in your web browser (see below)
3. Log into Patient Connect using your BU Kerberos account issued by the university and then verify your date of birth.

4. Once logged in, click on the word “Forms” from the menu bar (see below)
5. **Click on “Immunization and Physical Form Upload” (see below)**

6. **Click on the button “Add Immunization record…” and attach the images of your Immunization and Physical Form that you took on your phone or scanned on your computer (see below).**
7. Click on the word “Submit Final” in the blue box.
### IMMUNIZATION & PHYSICAL FORM – CELOP

**PLEASE UPLOAD ONLINE ON OUR HEALTH PORTAL “PATIENT CONNECT”** [bu.edu/patientconnect](http://bu.edu/patientconnect)

**FORM IS DUE PRIOR TO MATRICULATION. WE CANNOT ACCEPT ANY MEDICAL DOCUMENTS VIA EMAIL.**

### PART 1: COMPLETED BY THE STUDENT

**ALL INFORMATION MUST BE PRINTED LEGIBLY OR FORM CANNOT BE PROCESSED**

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Middle Initial:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Enter Last Name]</td>
<td>[Enter First Name]</td>
<td>[Enter Initial]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DOB (mm/dd/yy):</th>
<th>Date of Entry to BU (month/year):</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Enter DOB on Date of Birth]</td>
<td>[Enter Month and Year of Entry]</td>
</tr>
</tbody>
</table>

**Active Email Address:**

**Please Check:**

- [ ] University Housing
- [ ] Commuter
- [ ] Undergraduate
- [ ] Graduate
- [ ] Clinical/Medical

**Student’s Cell Phone #:**

- [ ] [Enter Student’s Cell Phone #]
- [ ] [Enter Carrier]

**School, College, or Program at BU:**

- [ ] [Enter School, College, or Program]

**For comprehensive information about Student Health Services, including hours and directions, please visit:**

[www.bu.edu/shs](http://www.bu.edu/shs)

### PART 2: REQUIRED IMMUNIZATIONS PRIOR TO ARRIVAL AT BU

**VERIFIED AND SIGNED BY HEALTH CARE PROVIDER (MD/NP/PA)**

**A. MMR (Measles, Mumps, Rubella)**

Two doses of MMR vaccine (after 1st birthday), two doses of each individual component, OR positive titers.

<table>
<thead>
<tr>
<th>MMR Vaccination #1 (oldest):</th>
<th>MMR Vaccination #2 (newest):</th>
</tr>
</thead>
<tbody>
<tr>
<td>mm/dd/yyyy</td>
<td>mm/dd/yyyy</td>
</tr>
<tr>
<td>MUST BE GIVEN AFTER 1st BIRTHDAY</td>
<td>Minimum of 4 weeks after 1st dose</td>
</tr>
</tbody>
</table>

**Measles Vaccination:**

- [ ] #1 mm/dd/yyyy
- [ ] #2 mm/dd/yyyy

**Mumps Vaccination:**

- [ ] #1 mm/dd/yyyy
- [ ] #2 mm/dd/yyyy

**Rubella Vaccination:**

- [ ] #1 mm/dd/yyyy
- [ ] #2 mm/dd/yyyy

**Positive Titers:**

- [ ] Measles Titer mm/dd/yyyy
- [ ] Mumps Titer mm/dd/yyyy
- [ ] Rubella Titer mm/dd/yyyy

**B. Tdap (Tetanus, Diphtheria, & Pertussis)**

Must be within the past 10 years. No other form of the Tetanus shot is acceptable.

<table>
<thead>
<tr>
<th>Tdap Vaccination:</th>
</tr>
</thead>
<tbody>
<tr>
<td>mm/dd/yyyy</td>
</tr>
</tbody>
</table>

(Td shot is not acceptable, must be Tdap)

*If not available in your country, leave blank and receive at SHS

**BU Student ID #:**

Necessary for all students

U _ _ _ _ _ _ _
### Meningitis

One dose within 5 years for all students living on campus required or a completed waiver. A dose after age 16 is recommended for maximal protection.

<table>
<thead>
<tr>
<th>Meningitis Vaccination:</th>
<th>Menactra</th>
<th>Menomune</th>
</tr>
</thead>
<tbody>
<tr>
<td>mm/dd/yyyy</td>
<td>mm/dd/yyyy</td>
<td></td>
</tr>
</tbody>
</table>

**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 reviewed the Meningococcal Information section of the SHS Immunization page: [www.bu.edu/shs/immunizations](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)

### Hepatitis B

Completed 3 part series required or proof of a positive titer.

<table>
<thead>
<tr>
<th>Hep B Vaccination #1 (oldest)</th>
<th>Hep B Vaccination #2</th>
<th>Hep B Vaccination #3 (newest)</th>
</tr>
</thead>
<tbody>
<tr>
<td>mm/dd/yyyy</td>
<td>mm/dd/yyyy</td>
<td>mm/dd/yyyy</td>
</tr>
</tbody>
</table>

Hepatitis B Positive Titer: mm/dd/yyyy

### Varicella

Two doses required, or proof of a positive titer, or a history of the disease verified by your health care provider.

<table>
<thead>
<tr>
<th>Varicella Vaccination #1 (oldest):</th>
<th>Varicella Vaccination #2 (newest):</th>
</tr>
</thead>
<tbody>
<tr>
<td>mm/dd/yyyy</td>
<td>mm/dd/yyyy</td>
</tr>
</tbody>
</table>

Varicella Positive Titer: mm/dd/yyyy

Date of Disease: mm/dd/yyyy

Must include the month, date, and year to be accepted.
PART 3: REQUIRED TUBERCULOSIS(TB) HISTORY PRIOR TO ARRIVAL AT BU
COMPLETED BY STUDENT AND SIGNED BY HEALTH CARE PROVIDER (MD/NP/PA)

A. General Tuberculosis History
Have you had a positive tuberculosis skin test in the past?  
YES (Complete Section B)  NO (Complete Section C)

B. Positive Tuberculosis & Evaluation/Treatment History

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

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

Have you ever had a BCG Vaccine?  No / Yes  If yes, what was the date of the vaccine? ____/_____/____

Chest X-Ray Date: _____/_____/____  Result: □ Normal □ Abnormal (describe) ____________________________

Clinical Evaluation Date: _____/_____/____ (Must be within 1 year of matriculation)
□ Normal (Absence of cough, hemoptysis, fevers, chills, sweats, weight loss)
□ Abnormal (describe): ________________________________________________________________

Treatment Date Range: _____/_____/____
□ Yes (Drug, dose, frequency) ____________________________
□ No (Please document the reason prophylaxis or treatment was not done): ________________________

C. Negative Tuberculosis History

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/tb
4. Have you completed 6-9 months of medication to prevent active tuberculosis?  YES  NO
   (i.e. isoniazid)

If you answered YES to any of the previous questions (1-4) you must provide proof of a recent tuberculosis test administered within the last year in the table below:

<table>
<thead>
<tr>
<th>Tuberculosis Skin Test</th>
<th>Plant Date</th>
<th>Read Date</th>
<th>MM</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Must be within the past year)</td>
<td><em><strong><strong>/</strong></strong></em>/____</td>
<td><em><strong><strong>/</strong></strong></em>/____</td>
<td>______</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>QuantiFERON Gold Test</th>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em><strong><strong>/</strong></strong></em>/____</td>
<td>____ Positive ___ Negative</td>
</tr>
</tbody>
</table>

Clinician’s Name, MD/NP/PA (please print)  Signature  Date  
BU ID # __________________________
### PART 4: OPTIONAL IMMUNIZATIONS PRIOR TO ARRIVAL AT BU

**VERIFIED AND SIGNED BY HEALTH CARE PROVIDER (MD/NP/PA)**

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Influenza</strong></td>
<td>One dose of vaccination every year is highly recommended.</td>
</tr>
<tr>
<td>Influenza Vaccination (most recent):</td>
<td>___ / ___ / _____</td>
</tr>
<tr>
<td>mm</td>
<td>dd</td>
</tr>
<tr>
<td><strong>B. Polio</strong></td>
<td>Those traveling to areas where polio is common should consider an additional 1-2 doses of vaccine.</td>
</tr>
<tr>
<td>Polio Vaccination #1 (oldest):</td>
<td>___ / ___ / _____</td>
</tr>
<tr>
<td>mm</td>
<td>dd</td>
</tr>
<tr>
<td>Polio Vaccination #2 (newest):</td>
<td>___ / ___ / _____</td>
</tr>
<tr>
<td>mm</td>
<td>dd</td>
</tr>
<tr>
<td><strong>C. Hepatitis A</strong></td>
<td>Two vaccinations should be given 6 months apart from one another.</td>
</tr>
<tr>
<td>Hepatitis A Vaccination #1 (oldest):</td>
<td>___ / ___ / _____</td>
</tr>
<tr>
<td>mm</td>
<td>dd</td>
</tr>
<tr>
<td>Hepatitis A Vaccination #2 (newest):</td>
<td>___ / ___ / _____</td>
</tr>
<tr>
<td>mm</td>
<td>dd</td>
</tr>
<tr>
<td><strong>D. Typhoid</strong></td>
<td>The injection lasts for 2 years. The oral vaccine lasts for 5 years.</td>
</tr>
<tr>
<td>Typhoid Injection:</td>
<td>___ / ___ / _____</td>
</tr>
<tr>
<td>mm</td>
<td>dd</td>
</tr>
<tr>
<td>OR</td>
<td>Typhoid Oral Vaccination:</td>
</tr>
<tr>
<td>mm</td>
<td>dd</td>
</tr>
<tr>
<td><strong>E. Yellow Fever</strong></td>
<td>One vaccination lasts for 10 years.</td>
</tr>
<tr>
<td>Yellow Fever Vaccination:</td>
<td>___ / ___ / _____</td>
</tr>
<tr>
<td>mm</td>
<td>dd</td>
</tr>
<tr>
<td><strong>F. TwinRix (Combination of Hep A and Hep B)</strong></td>
<td>Three doses given over the course of 6 months.</td>
</tr>
<tr>
<td>TwinRix Vaccination #1 (oldest):</td>
<td>___ / ___ / _____</td>
</tr>
<tr>
<td>mm</td>
<td>dd</td>
</tr>
<tr>
<td>TwinRix Vaccination #2:</td>
<td>___ / ___ / _____</td>
</tr>
<tr>
<td>mm</td>
<td>dd</td>
</tr>
<tr>
<td>TwinRix Vaccination #3 (newest):</td>
<td>___ / ___ / _____</td>
</tr>
<tr>
<td>mm</td>
<td>dd</td>
</tr>
<tr>
<td><strong>G. HPV (Human Papilloma Virus)</strong></td>
<td>1st dose to be followed by 2nd dose after two months, followed by 3rd dose six months after 1st dose.</td>
</tr>
<tr>
<td>HPV Vaccination #1 (oldest):</td>
<td>___ / ___ / _____</td>
</tr>
<tr>
<td>mm</td>
<td>dd</td>
</tr>
<tr>
<td>HPV Vaccination #2:</td>
<td>___ / ___ / _____</td>
</tr>
<tr>
<td>mm</td>
<td>dd</td>
</tr>
<tr>
<td>HPV Vaccination #3 (newest):</td>
<td>___ / ___ / _____</td>
</tr>
<tr>
<td>mm</td>
<td>dd</td>
</tr>
</tbody>
</table>

### PART 5: RECOMMENDED PHYSICAL INFORMATION

**VERIFIED AND SIGNED BY MD/NP/PA**

*This form may be submitted without a physical*

Date of physical exam (must be within 1 year of matriculation): ___ / ___ / _____ MM / DD / YYYY

*NCAA Varsity Athletes: Per NCAA Bylaw 77.1.5: Within six months prior to participation in any practice, competition or out-of-season conditioning activities, student-athletes shall be required to undergo a medical examination or evaluation administered by a physician.*

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 - (If no, please explain): ___________________________________________________________________________________

Clinician’s Name, MD/NP/PA (please print)  
Signature  
Date  
BU ID # ______________________
Massachusetts State Immunization Requirements
These **must** be completed **prior** to arrival on campus.

**Part 1A.** 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.

**Part 1B.** A booster of Tdap (tetanus, diphtheria, and pertussis) within the last 10 years.

**Part 1C.** One dose of Meningitis vaccine for all students who are living on campus. This vaccine must be administered within the last 5 years. A dose after age 16 is recommended for maximal protection.

**Part 1D.** Three doses of Hepatitis B vaccine or a positive blood test indicating immunity to Hepatitis B.

**Part 1E.** Two doses of the Varicella (chicken pox) vaccine given 4-8 weeks apart or a positive blood test indicating immunity to the chicken pox. If you have had the disease, your health care provider must document both the month and year of disease.

**Part 3A.** Please read through this entire section for requirements on Tuberculosis.

The month, day, and year of the immunization must be provided.

Such statements as “received as a child”, “records were lost”, “up to date”, or “scheduled” are not accepted.

All immunization forms must be signed by a health care provider (MD/NP/PA) or you must submit signed copies of your original immunization records.

The only circumstances under which a student may be exempt from submitting proof of immunizations:
- A physician certifies that a medical condition precludes immunization
- The student meets with a provider from SHS to discuss and states in writing that the required immunizations would conflict with their 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.
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

<table>
<thead>
<tr>
<th>Medication, dose, directions</th>
<th>Condition addressed by this medication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
Student Information
(To be completed by the student)

We at Student Health Services recognize that this time in your life can be both exciting and stressful. We want to be sure you know that free evaluations, short-term counseling and medication management are available in our Behavioral Medicine Department. If you find that you are feeling anxious, depressed or overwhelmed with new experiences that college has to offer, please call or stop by to access our confidential services.

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 the questions.

1. Have you ever been on medications for a mental health problem including depression, anxiety, bipolar disorder or other psychological disorders?
   Yes    No

2. Have you ever been hospitalized for a mental health problem, including an eating disorder or substance abuse?
   Yes    No

3. If yes to any of the above questions, would you like to be contacted by a Behavioral Medicine provider?
   Yes    No

Mental Health Resources

Boston University Student Health Services
Behavioral Medicine Department       (617) 353-3569

The Danielsen Institute               (617) 353-3047

The Center for Anxiety and Related Disorders (617) 353-9610

The Center for Psychiatric Rehabilitation (617) 353-3549

Please visit our mental health resources website at www.bu.edu/mentalhealth.

Students with Disabilities

Students with a disability of any kind may request accommodations through the Office of Disability Services. Since it may take some time for this process, please check the website www.bu.edu/disability and/or contact the Office of Disability Services as soon as possible: (617) 353-3658. For students with ADD/HD who will require prescription medication, we require a report of psychological testing confirming this diagnosis from within the prior three years. If you are in need of testing and wish to have it when you come to Boston University, please call Behavioral Medicine at (617) 353-3569 for information on beginning this process.
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 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)