University ID Number (8 or 9 digits)

Boston University Student Health Services
881 Commonwealth Ave. West, Boston, MA 02215
Phone: 617-353-3575 | Website: bu.edu/shs/compliance
Send us a message: patientconnect.bu.edu

IMMUNIZATION REQUIREMENTS FORM - CLINICAL

These vaccines are either required by the Commonwealth of Massachusetts or Boston University. You must complete this form with your licensed medical provider and then submit this form following the instructions on the bu.edu/shs/compliance page at least one month prior to the start of your first semester. If you haven't received all vaccines, you should still submit this form and receive the remaining vaccines at a later date while on campus at our clinic.

Last Name	First	Middle

Date of Birth mm/dd/yyyy	University ID Number (8 or 9 digits)	Semester Start (check one):
		☐ Fall ☐ Spring ☐ Summer 20_____

Measles-Mumps-Rubella	Two doses given at least 28 days apart and after 12 months of age. If given as single antigen vaccines, 2 Measles, 2 Mumps and 2 Rubella doses are required **OR** positive MMR antibody titer. Doses of Varicella and MMR must be given on the same day or 28 days apart. Doses administered at less than the minimum interval or earlier than the minimum age are not valid and must be repeated.			
MMR	Dose 1 mm/dd/yyyy	Dose 2 mm/dd/yyyy		
OR				
Measles	Dose 1 mm/dd/yyyy	Dose 2 mm/dd/yyyy	**OR**	Positive Titer mm/dd/yyyy
Mumps	Dose 1 mm/dd/yyyy	Dose 2 mm/dd/yyyy	**OR**	Positive Titer mm/dd/yyyy
Rubella	Dose 1 mm/dd/yyyy	Dose 2 mm/dd/yyyy	**OR**	Positive Titer mm/dd/yyyy

Varicella	Two doses given at least 4 weeks apart and after 12 months of age **OR** positive Varicella antibody titer. Doses administered at less than the minimum interval or earlier than the minimum age are not valid and must be repeated.		
Dose 1 mm/dd/yyyy	Dose 2 mm/dd/yyyy	**OR**	Positive Titer mm/dd/yyyy

Hepatitis B	A minimum of 4 weeks between doses 1 and 2 and a minimum of 16 weeks between doses 1 and 3 **AND** a positive Hepatitis B antibody titer. Please attach the specific vaccine or titer verification from a medical provider.		
Vaccine	☐ HepB (3-dose series)	☐ Heplisav-B (HepB-CpG, 2-dose series)	☐ Combination Hepatitis A & B vaccine (TwinRix)
Doses	Dose 1 mm/dd/yyyy	Dose 2 mm/dd/yyyy	Dose 3 mm/dd/yyyy
AND			
Antibody Titer	Antibody Titer mm/dd/yyyy		

Meningococcal Conjugate (ACWY)	One dose on or after your 16th birthday is required. Do not complete this section if you will be over 21 years of age at the start of your first semester. The Meningococcal B vaccine does not fulfill the requirement. Instructions to decline the Meningitis (ACWY) vaccine requirement can be found on this link.
mm/dd/yyyy	

Tetanus-Diphtheria-Pertussis (Tdap)	One dose on or after 10 years of age is required. If you received multiple doses of Tdap, include most recent dose. A Tdap booster is recommended every 10 years.
Tdap	mm/dd/yyyy

(continued on second page) ➡

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IMMUNIZATION VACCINATION REQUIREMENTS *(continued)*

Tuberculosis (TB) Test

TB Test History

All clinical students are required to complete **a TB Symptom Screen along with a TB blood test (T-Spot or Quantiferon Gold) completed** no more than three months prior to the semester start date. Students will need to fulfill TB symptom screen annually while attending BU. If TB testing is not available in your country or you are unable to complete TB prior to your arrival at BU, you should still submit this form and arrange an appointment at SHS to have the IGRA blood test.

If you have already had a positive TB skin or blood test in the past, do not repeat a TB test and fill out the Positive TB History section.

IGRA T-Spot Blood Test	Date of Test mm/dd/yyyy	Result ☐ Positive ☐ Negative
OR		
Quantiferon Gold Blood Test	Date of Test mm/dd/yyyy	Result ☐ Positive ☐ Negative

Positive TB History Please complete this section if you have ever had a positive TB skin or blood test and/or have ever received treatment for TB.

Chest X-Ray	Date Given mm/dd/yyyy	Result ☐ Normal ☐ Abnormal	Describe:
Clinical Evaluation	Date of Appointment mm/dd/yyyy	Result ☐ Normal ☐ Abnormal	Describe:
Treatment	Date of Treatment mm/dd/yyyy	If Yes, drug, dose, & frequency: Yes ☐	If No, reason why treatment not done: No ☐

Authorization & Consent

☐ I hereby authorize the clinical staff at Boston University (BU) Student Health Services (SHS) to examine and treat me during my enrollment at BU, and agree to the following:

- I understand that there is no charge to see a provider at BU SHS.
- I understand that I am responsible for miscellaneous charges including, but not limited to, lab tests, immunizations, and some supplies.
- I understand that I am responsible for all health care charges outside of SHS (except those covered by my health insurance).
- I understand that SHS includes medical, mental health, nutrition, sports medicine, athletic training services, 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.
- I understand that immunization information may be reported to the school or program in which I am enrolled.
- I understand that SHS endeavors to serve all students eligible for care, but that there may be circumstances when referral to outside providers in the community is necessary.
- The information on this form is for the use of SHS. As with all information SHS holds related to my health, it will not be released to a third party without my consent, except as necessary to fulfill the responsibilities of SHS or as required or permitted by law.

Student Name		Student Signature _____

LICENSED MEDICAL PROVIDER (MD, DO, PA, NP, RN, MBBS) VERIFICATION *(required)*

Provider Printed Name First Last Phone

Provider Signature/Credentials _____ Date m m / d d / y y y y