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

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 **OR** a history of the disease verified by your provider. 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	**OR**	Disease Date 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 **OR** 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
OR			
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 your 10th birthday 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 REQUIREMENTS FORM *(continued)*

TB Questions — Tuberculosis (TB) Test

Have you worked or lived with someone with active TB(or will you prior to your arrival in the United States)?	☐ Yes ☐ No	If Yes, explain:
Were you born in, lived in, or have you traveled for more than one month to any of the high risk countries found here: bu.edu/shs/tb	☐ Yes ☐ No	If Yes, explain:
Have you ever tested positive for TB or completed 6-9 months of medication to prevent active TB? (i.e. isoniazid)	☐ Yes ☐ No	If Yes, explain:

TB Test History

If you answered **no to all of the questions above**, please skip to the "Authorization & Consent" section. If you answered **yes to the first two questions above**, a TB skin test or IGRA blood test must be completed no more than six months prior to the semester start date. If you answered **yes to the last question above and have ever had a positive TB test in the past,** do not repeat a TB test and fill out the Positive TB Test History section.

TB Skin Test	Date Given mm/dd/yyyy	Date Read mm/dd/yyyy	Result ☐ Positive ☐ Negative ☐ Indeterminate — Induration (recorded in mm)
OR			
IGRA Blood Test	Date of Test mm/dd/yyyy		Result ☐ Positive ☐ Negative ☐ Indeterminate

Positive TB Test History

Please complete this section if you have ever had a positive TB skin 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

A parent/guardian must acknowledge and sign this section if the student is under the age of 18 on the first day of classes. Additional resources for parents/guardians can be found under bu.edu/shs/parents.

☐ I hereby authorize the clinical staff at Boston University (BU) Student Health Services (SHS) to examine and treat me during my enrollment at BU. I understand that there is no charge to see a provider at BU SHS. However, 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 that which is covered by my health insurance). I understand that SHS is a unit inclusive of 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. 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. The information on this form is for the use of SHS and will not be released to a third party without your consent, except as necessary to fulfill the responsibilities of SHS or as required or permitted by law.

Student Name		Student Signature
Parent/Guardian Name *(required if student under the age of 18)*		Parent Signature

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

Provider Printed Name (First / Last) _____ Phone

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