Required Immunization Form

Please fax or mail this form to:
Boston University Summer Term
200 Riverway, Suite 114
Boston, MA 02215
Fax: 617-353-5532

Vaccines | Dates Given | Massachusetts State Requirements
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**MMR** | #1 ___ / ___ / ___ | • 2 doses of MMR
| Oldest | #2 ___ / ___ / ___ | • Minimum of 4 weeks between doses
| Newest | MM DD YYYY | • 1st dose given after 1st birthday

**Measles** | #1 ___ / ___ / ___ | • If given as single vaccines, 2 Measles, 2 Mumps, 2 Rubella
| Oldest | #2 ___ / ___ / ___ | • Minimum of 4 weeks between doses
| Newest | MM DD YYYY | • 1st dose given after 1st birthday

**Mumps** | #1 ___ / ___ / ___ | • Minimum of 4 weeks between doses
| Oldest | #2 ___ / ___ / ___ | • 1st dose given after 1st birthday
| MM DD YYYY | MM DD YYYY |

**Rubella** | #1 ___ / ___ / ___ | • Minimum of 4 weeks between doses
| Oldest | #2 ___ / ___ / ___ | • 1st dose given after 1st birthday
| MM DD YYYY | MM DD YYYY |

**Positive Titers**

**Measles Titer Date:**  ____/____/____

**Mumps Titer Date:**  ____/____/____

**Rubella Titer Date:**  ____/____/____

**Tdap** | ___ / ___ / ___ | • Tdap (Tetanus, Diphtheria & Pertussis) is only acceptable form of Tetanus shot
| MM DD YYYY | • Must be within the last 10 years

**Meningitis** | / / / | If living on campus: one dose on or after 16th birthday or completed waiver (page 2)
| MM DD YYYY | Menomune OR Menactra OR Waiver

**Hepatitis B** | #1 ___ / ___ / ___ | • Three doses of Hepatitis B vaccine (or appropriately timed 2-dose series)
| Oldest | #2 ___ / ___ / ___ | • Tdap
| #3 ___ / ___ / ___ | (Tetanus, Diphtheria & Pertussis)
| MM DD YYYY | OR
| MM DD YYYY | (or appropriately timed 2-dose series)
| MM DD YYYY | OR

**Positive Titer**

**Hepatitis B Titer Date:**  ____/____/____

**Varicella** | #1 ___ / ___ / ___ | • 2 doses of varicella vaccine
| Oldest | #2 ___ / ___ / ___ | • Minimum of 4 weeks between doses
| MM DD YYYY | MM DD YYYY |

**Titer** | Positive Titer Date  ____/____/____ | Positive titer
| MM DD YYYY |

**Disease** | Date of Disease  ____/____/____ | History of disease verified by a medical provider
| MM DD YYYY |
Meningococcal Waiver is ONLY if you wish to waive the requirement for the Meningococcal Vaccine.

**Waiver for Meningococcal Vaccination Requirement**

I have reviewed the risks of meningococcal disease and the risks and benefits of the meningococcal vaccine, available at www.bu.edu/shs/immunizations. 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 post-secondary 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.

Please check the appropriate box below.

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

-OR-

☐ Due to the shortage of meningococcal vaccine, I was unable to be vaccinated, but wish to receive the vaccine.

Student Name:  _______________________________________ Date of Birth: _________________

Student ID # (if known):  _________________________________

Signature:  ___________________________________________ Date:  _________________

(Signature of student or parent/legal guardian, if student is under 18 years of age)

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**Tuberculosis (TB) Record**

1. Have you had a positive TB skin test in the past?  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 a high risk country?  Yes  No (see CDC website for guidelines)

4. Have you traveled or lived for more than one month in any of the high risk countries?  Yes  No

5. Have you completed 6-9 months of medication (i.e. isoniazid) to prevent active tuberculosis (tuberculosis prophylaxis)?  Yes  No

If you have a history of a positive tuberculosis skin test and have never taken medication to prevent active tuberculosis, please report to Student Health Services on arrival to campus to discuss this treatment.

If you answered YES to number 2, 3, or 4, please provide documentation of a recent tuberculosis skin test (TST) administered within the past year.

Tuberculosis skin test date  ________________  Result  ________________ mm  Interpretation (check one)  Pos  Neg

If you previously received BCG vaccine, a blood test such as Quantiferon Gold or T-spot is the preferred test to indicate absence of TB.

Date  ________________  Result (check one)  Pos  Neg

If a current or past tuberculosis skin test is/was positive, please indicate evaluation/treatment.

Chest x-ray date  ________________  Result (check one)  Pos  Neg

Treatment:

☐ Yes_______________________________________________________________________________________

☐ No_______________________________________________________________________________________

(Please document reason prophylaxis or treatment not done)