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

Last Name ______ First Name ______ Date of Birth (MM/DD/YYYY) ______ Email Address ______

Vaccines	Dates Given	Massachusetts State Requirements
MMR	Oldest #1___/___/___ (MM DD YYYY) Newest #2___/___/___ (MM DD YYYY)	• 2 doses of MMR • Minimum of 4 weeks between doses • 1st dose given **after 1st birthday**
OR		OR
Individual Vaccines: Measles Mumps Rubella	**Measles** Oldest #1___/___/___ (MM DD YYYY) Newest #2___/___/___ (MM DD YYYY) **Mumps** Oldest #1___/___/___ (MM DD YYYY) Newest #2___/___/___ (MM DD YYYY) **Rubella** Oldest #1___/___/___ (MM DD YYYY) Newest #2___/___/___ (MM DD YYYY)	• If given as single vaccines: 2 Measles, 2 Mumps, 2 Rubella • Minimum of 4 weeks between doses • 1st dose given **after 1st birthday**
OR		OR
Positive Titers	Measles Titer Date: ____/____/____ (MM DD YYYY) Mumps Titer Date : ____/____/____ (MM DD YYYY) Rubella Titer Date : ____/____/____ (MM DD YYYY)	Positive Titers
Tdap	___/___/___ (MM DD YYYY) Td is NOT acceptable; **Tdap** (Tetanus, Diphtheria & Pertussis) is only acceptable form of Tetanus shot	Must be after 11th birthday and within the last 10 years
Meningitis	____/____/____ (MM DD YYYY) Menomune ☐ OR Menactra ☐ OR Waiver ☐	If living on campus: one dose on or after 16th birthday or completed waiver (page 2)
Hepatitis B	Oldest #1___/___/___ (MM DD YYYY) #2___/___/___ (MM DD YYYY) Newest #3 ___/___/___ (MM DD YYYY)	Three doses of Hepatitis B vaccine (or appropriately timed 2-dose series)
OR		OR
Positive Titer	Hepatitis B Titer Date ____/____/____ (MM DD YYYY)	Positive titer
Varicella	Oldest #1___/___/___ (MM DD YYYY) Newest #2___/___/___ (MM DD YYYY)	• 2 doses of varicella vaccine • Minimum of 4 weeks between doses • 1st dose given **after 1st birthday**
OR		OR
Titer	Positive Titer Date ____/____/____ (MM DD YYYY)	Positive titer
OR		OR
Disease	Date of Disease ____/____/____ (MM DD YYYY)	History of disease verified by a medical provider

Licensed Medical Provider MD/DO/PA/NP/RN name (please print) ______ Signature ______ Date ______

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: ____________________

Signature: ______________________________ Date: ____________________

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

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? (see CDC website cdc.gov/tb) Yes No
4. Have you traveled or lived for more than one month in any of the high risk countries? Yes No
5. Have you completed a treatment regimen for latent tuberculosis ? 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____

(Drug, Dose, Frequency, and Dates)

☐ No____

(Please document reason prophylaxis or treatment not done)