



## Required Immunization Form

Last Name First Name M.I.

Date of Birth (MM/DD/YYYY)

Active Email Address

Please fax or mail this form to:  
Boston University Summer Term  
International Partnerships  
755 Commonwealth Ave, Room 105  
Boston, MA 02215  
Fax: 617-353-5322

Vaccines	Dates Given	Massachusetts State Requirements
<b>MMR</b>	Oldest #1 ___/___/___ MM DD YYYY Newest #2 ___/___/___ MM DD YYYY	<ul style="list-style-type: none"><li>2 doses of MMR</li><li>Minimum of 4 weeks between doses</li><li>1st dose given <b>after 1<sup>st</sup> birthday</b></li></ul>
<b>OR</b>		<b>OR</b>
Individual Vaccines: Measles Mumps Rubella	<b>Measles</b> Oldest #1 ___/___/___ MM DD YYYY Newest #2 ___/___/___ MM DD YYYY <b>Mumps</b> Oldest #1 ___/___/___ MM DD YYYY Newest #2 ___/___/___ MM DD YYYY <b>Rubella</b> Oldest #1 ___/___/___ MM DD YYYY Newest #2 ___/___/___ MM DD YYYY	<ul style="list-style-type: none"><li>2 doses of each individual component (2 measles, 2 mumps, and 2 rubella)</li><li>Minimum of 4 weeks between doses</li><li>1st dose given <b>after 1<sup>st</sup> birthday</b></li></ul>
<b>OR</b>		<b>OR</b>
Positive Titers	Measles Titer Date: ___/___/___ MM DD YYYY Mumps Titer Date : ___/___/___ MM DD YYYY Rubella Titer Date : ___/___/___ MM DD YYYY	Positive Titers
<b>Tdap</b>	___/___/___ MM DD YYYY (Td in NOT acceptable, must be Tdap)	<b>Tdap (Tetanus, Diphtheria &amp; Pertussis) is the only acceptable form of Tetanus shot</b> (Must be within last 10 years)
<b>Meningitis</b>	___/___/___ MM DD YYYY Menomune OR Menactra OR Waiver <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	One dose for incoming students living on campus within 5 years or completed waiver (page 2)
<b>Hepatitis B</b>	Oldest #1 ___/___/___ MM DD YYYY Newest #2 ___/___/___ MM DD YYYY #3 ___/___/___ MM DD YYYY	Completed 3 part series
<b>OR</b>		<b>OR</b>
Positive Titer	Hepatitis B Titer Date ___/___/___ MM DD YYYY	Positive titer
<b>Varicella</b>	Oldest #1 ___/___/___ MM DD YYYY Newest #2 ___/___/___ MM DD YYYY	2 doses of varicella vaccine
<b>OR</b>		<b>OR</b>
Titer	Positive Titer Date ___/___/___ MM DD YYYY	Positive titer
<b>OR</b>		<b>OR</b>
Disease	Date of Disease ___/___/___ MM DD YYYY	History of disease must be verified by a medical provider

Clinician name MD/NP/PA (please print)

Signature

Date

Meningococcal Waiver is **ONLY** if you plan on waiving the requirement for the Meningococcal Vaccine. If you have received the vaccine, please ignore the waiver and proceed to the next page.

### Waiver for Meningococcal Vaccination Requirement

I have received and reviewed the Meningococcal Information Form provided on the risks of meningococcal disease and the risks and benefits of meningococcal vaccine (available at [www.bu.edu/shs/forms](http://www.bu.edu/shs/forms)). 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 postsecondary 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 meningococcal vaccine.

-OR-

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

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Student ID#: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(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?<br>(see CDC website for guidelines)   | 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 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, you need to 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 TSpot 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, you will need to complete the following 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)