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

IMMUNIZATION REQUIREMENTS FORM - SUMMER

These vaccines are either required by the Commonwealth of Massachusetts or Boston University. You must complete this form with your licensed medical provider and upload it with your participation agreement.

Last Name	First	Middle

Date of Birth mm/dd/yyyy	University ID Number (8 or 9 digits) ***For BU Office use only***	Summer Program Name/Type

Emergency Contact Name	Relationship	Phone Number

Alternate Emergency Contact Name	Relationship	Phone Number

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 program. 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 countries of high incidence found here.	☐ 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 may be charges to see a provider at BU SHS for an office visit and 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

MIIS FAQs: Sharing Your Immunization Information

What is the Massachusetts Immunization Information System?

The Massachusetts Immunization Information System (MIIS), also called an immunization registry, is a confidential, web-based system that collects and stores vaccination (shot) records for people of all ages vaccinated in Massachusetts. The MIIS is operated by the Immunization Division at the Massachusetts Department of Public Health and helps you, along with your healthcare providers, keep track of the shots that you have received.

Why is the MIIS important?

The schedule of vaccines that you need to stay healthy and that are required for you becomes more complicated with every new vaccine introduced. Keeping all your shot records in one place helps to make sure that you receive the complete schedule of immunizations.

What information about me will be entered into the MIIS?

Boston University Student Health Services is mandated to report any immunizations we administer to the MIIS. Other information, including address, date of birth, sex, and the provider office location will also be included in the registry to be sure that your records are accurate and cannot be confused with another patient's record. All the information in the MIIS is secure and confidential.

What if I do not want to share my immunization information?

The law requires that immunizations are reported to the Massachusetts Department of Public Health through the MIIS. There is no option to "opt-out" of the MIIS. Your records will only be available to those involved in your care, who have a reason to know about them. The MIIS enables Student Health Services to verify what shots you have received in the past from other providers. If you prefer that your immunization history not be viewed by new providers, you may object to sharing your immunization information.

If you object to data sharing, your immunization information will still be in the MIIS, but only the provider(s) who administered your vaccines and the Department of Public Health will be able to see it. To object to data sharing, you must complete the MIIS Objection (or Withdrawal of Objection) Form. If you change your mind, you can fill out the same form to have your immunization information shared in the MIIS.

Please note: you will need to keep track of your records in the event that you receive immunizations from other health care providers.

For more information about the MIIS visit their website: https://www.mass.gov/massachusetts-immunization-information-system-miis