

# IMMUNIZATION & PHYSICAL FORM

THIS FORM IS DUE PRIOR TO THE START OF THE SCHOOL YEAR. YOUR CHILD'S HEALTHCARE PROVIDER SHOULD COMPLETE PARTS 2-5 AND SIGN ALL SUBSEQUENT PAGES. ALL MATERIALS ARE REQUESTED BY AUGUST 15, 2017.

## PART 1: TO BE COMPLETED BY THE FAMILY

Last Name:	First Name:	Middle Initial:
DOB (mm/dd/yy):	Grade in AY2017-2018:	
BUID # (if known):		

## PART 2: REQUIRED IMMUNIZATIONS PRIOR TO START OF SCHOOL VERIFIED AND SIGNED BY HEALTH CARE PROVIDER (MD/NP/PA)

### A. MMR (Measles, Mumps, Rubella)

Two doses of MMR vaccine (after 1<sup>st</sup> birthday), two doses of each individual component, OR positive titers.

MMR Vaccination #1 (oldest): Must be given after 1 <sup>st</sup> birthday		MMR Vaccination #2 (newest): Minimum of 4 weeks after 1 <sup>st</sup> dose	
mm / dd / yyyy		mm / dd / yyyy	
<b>OR</b>			
Measles Vaccination:	Mumps Vaccination:	Rubella Vaccination:	
#1 mm / dd / yyyy (oldest)	#1 mm / dd / yyyy (oldest)	#1 mm / dd / yyyy (oldest)	
#2 mm / dd / yyyy (newest)	#2 mm / dd / yyyy (newest)	#2 mm / dd / yyyy (newest)	
<b>OR</b>			
Positive Titers:	Measles Titer	Mumps Titer	Rubella Titer
	mm / dd / yyyy	mm / dd / yyyy	mm / dd / yyyy

### B. Tdap (Tetanus, Diphtheria, & Pertussis)

Dose at  $\geq 7$  years may be counted, but recommended at age 11-12. No other form of Tetanus shot is acceptable.

Tdap Vaccination:	mm / dd / yyyy	(Td shot is <b>not</b> acceptable, must be Tdap) *Leave blank if not available in your home country
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### C. Polio

4 doses of vaccine (last dose must be given on or after 4<sup>th</sup> birthday and  $\geq 6$  months after the previous dose, or a 5<sup>th</sup> dose is required); 3 doses are acceptable if the 3<sup>rd</sup> dose is given on or after 4<sup>th</sup> birthday and  $\geq 6$  months after the previous dose. In a mixed OPV/IPV schedule at least 4 doses are required, regardless of age.

#1 mm / dd / yyyy	#2 mm / dd / yyyy	#3 mm / dd / yyyy	#4 mm / dd / yyyy
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**D. Meningitis**

One dose within 5 years or a completed waiver. A dose after age 16 is recommended for maximal protection.

Meningitis Vaccination:

Menactra  
\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

OR

Menomune  
\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

**MENINGITIS WAIVER**

Meningococcal Waiver is **ONLY** if you plan on waiving the requirement for the Meningococcal Vaccine. If you have received the vaccine, please ignore this waiver.

**Waiver for Meningococcal Vaccination Requirement**

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

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

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**E. Hepatitis B**

Completed 3 part series required or proof of a positive titer.

Hep B Vaccination #1 (oldest)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

Hep B Vaccination #2

\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

Hep B Vaccination #3 (newest)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

OR

Hepatitis B Positive Titer: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

**F. Varicella**

Two doses required, or proof of a positive titer, or a history of chickenpox verified by your health care provider.

Varicella Vaccination #1 (oldest): \_\_\_\_/\_\_\_\_/\_\_\_\_  
Must be given after 1<sup>st</sup> birthday mm dd yyyy

Varicella Vaccination #2 (newest): \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

OR

Varicella Positive Titer: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

OR

Date of Disease: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

Must include the month, date, and year to be accepted.

Clinician's Name, MD/NP/PA (please print)

Signature

Date

## PART 3: PEDIATRIC TB RISK ASSESSMENT

### COMPLETED AND SIGNED BY HEALTH CARE PROVIDER (MD/NP/PA)

*The purpose of the TB Risk Assessment Form is to identify children who may be at increased risk for tuberculosis (TB) and may require evaluation and testing. A child with any risk factor described below is a candidate for TB testing, unless there is written documentation of a previous positive TB test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]).*

TB Risk Assessment	Yes	No
Was the child born in Africa, Asia and Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East? If yes, in what country was the child born? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has the child lived or traveled in Africa, Asia and Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East for more than one month? If yes, which country or countries? _____	<input type="checkbox"/>	<input type="checkbox"/>
In the last 2 years, has the child lived with or spent time with someone who has been sick with TB?	<input type="checkbox"/>	<input type="checkbox"/>
Have any members of the child's household come to the United States from another country? If yes, which country or countries? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does the child have any history of immunosuppressive disease or take medications that might cause immunosuppression?	<input type="checkbox"/>	<input type="checkbox"/>

#### Test for TB

Test, using a TST or IGRA, only those infants and children identified to be at risk of exposure to TB. Do **not** test infants and children at low risk for TB.

- IGRA is the preferred test for children 5 years of age and older with a history of BCG vaccination
- Use the Mantoux tuberculin skin test (5 TU PPD) for children of any age.

#### Report TB

Report newly diagnosed cases of latent TB infection and suspected or confirmed TB disease to the Massachusetts Department of Public Health.  
<http://www.mass.gov/eohhs/gov/departments/dph/programs/id/isis/case-report-forms.html>

#### Resources

Brochure "What Parents Need to Know About Tuberculosis (TB) Infection in Children", New Jersey

Medical School Global Tuberculosis Institute <http://globaltb.njms.rutgers.edu/downloads/products/tbpedsbrochure.pdf>

Screening Infants and Children for Tuberculosis in Massachusetts, MDPH 2014 <http://www.mass.gov/eohhs/docs/dph/cdc/tb/recommendations-screening-children-tb.pdf>

CDC recommendations on TB evaluation, testing and treatment in children <http://www.cdc.gov/tb/topic/populations/TBinChildren/default.htm>

CDC Guidelines for the Prevention and Treatment of Opportunistic Infections among HIV-Exposed and HIV-Infected Children. MMWR September 2009  
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5811a1.htm>

MDPH supported TB clinics <http://www.mass.gov/eohhs/gov/departments/dph/programs/id/tb/public-health-cdc-tb-clinics.html>

Clinician's Name, MD/NP/PA (please print)

Signature

Date

## PART 4: REQUIRED PHYSICAL EXAMINATION AND SPORTS RELEASE

MUST BE COMPLETED BY HEALTH CARE PROVIDER (MD/NP/PA)

### A. Physical Exam and Sports Release

Must be within one year of matriculation.

Date of most recent physical exam: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

This student has been evaluated to be in good health and able to participate in the school's required physical education program as well as competitive athletics, if s/he chooses to do so:

☐ Yes ☐ Yes with restrictions *Please explain below.* ☐ No *Please explain below.*

## PART 5: OPTIONAL IMMUNIZATIONS

### A. Influenza

One dose of vaccination every year is highly recommended.

Influenza Vaccination (most recent): \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

### B. Hepatitis A

Two vaccinations should be given 6 months apart from one another.

Hepatitis A Vaccination #1 (oldest): \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

Hepatitis A Vaccination #2 (newest): \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

### C. Typhoid

The injection lasts for 2 years. The oral vaccine lasts for 5 years.

Typhoid Injection: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

OR

Typhoid Oral Vaccination: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

### D. Yellow Fever

One vaccination lasts for 10 years.

Yellow Fever Vaccination: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

### E. TwinRix (Combination of Hep A and Hep B)

Three doses given over the course of 6 months.

TwinRix Vaccination #1 (oldest):

\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

TwinRix Vaccination #2:

\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

TwinRix Vaccination #3 (newest):

\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

### F. HPV (Human Papilloma Virus)

1<sup>st</sup> dose to be followed by 2<sup>nd</sup> dose after two months, followed by 3<sup>rd</sup> dose six months after 1<sup>st</sup> dose.

HPV Vaccination #1 (oldest):

\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

HPV Vaccination #2:

\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

HPV Vaccination #3 (newest):

\_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yyyy

Clinician's Name, MD/NP/PA (please print)

Signature

Date

