BOSTON UNIVERSITY ACADEMY

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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, 2018; PLEASE DO NOT SEND ANY MEDICAL DOCUMENTS VIA EMAIL.

PART 1: TO BE COMPLETED BY THE FAMILY

Last Name:	First Name:	Middle Initial:
DOB (mm/dd/yy):	Grade in 2018-2019:	
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 1st birthday), two doses of each individual component, OR positive titers.

MMR Vaccination #1 (oldest): ___/ ___/ _____ (mm dd yyyy)
Must be given after 1st birthday

MMR Vaccination #2 (newest): ___/ ___/ _____ (mm dd yyyy)
Minimum of 4 weeks after 1st dose

OR

Measles Vaccination:
#1 ___/ ___/ _____ (oldest) (mm dd yyyy)
#2 ___/ ___/ _____ (newest) (mm dd yyyy)

Mumps Vaccination:
#1 ___/ ___/ _____ (oldest) (mm dd yyyy)
#2 ___/ ___/ _____ (newest) (mm dd yyyy)

Rubella Vaccination:
#1 ___/ ___/ _____ (oldest) (mm dd yyyy)
#2 ___/ ___/ _____ (newest) (mm dd yyyy)

OR

Positive Titers:

Measles Titer ___/ ___/ _____ (mm dd yyyy)

Mumps Titer ___/ ___/ _____ (mm dd yyyy)

Rubella Titer ___/ ___/ _____ (mm dd yyyy)

B. Tdap (Tetanus, Diphtheria, & Pertussis)

Dose at ≥ 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 **not** acceptable, must be Tdap)
*Leave blank if not available in your home country

C. Polio

4 doses of vaccine (last dose must be given on or after 4th birthday and ≥ 6 months after the previous dose, or a 5th dose is required); 3 doses are acceptable if the 3rd dose is given on or after 4th birthday and ≥ 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)

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 reviewed the meningococcal information section of the BU Student Health Services Immunization page: www.bu.edu/shs/immunizations). 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): ___/___/______ (mm dd yyyy)
Must be given after 1st birthday

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? ______________________	☐	☐
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? ______________________	☐	☐
In the last 2 years, has the child lived with or spent time with someone who has been sick with TB?	☐	☐
Have any members of the child's household come to the United States from another country? If yes, which country or countries? ______________________	☐	☐
Does the child have any history of immunosuppressive disease or take medications that might cause immunosuppression?	☐	☐

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):	TwinRix Vaccination #2:	TwinRix Vaccination #3 (newest):
___/ ___/ _____ mm dd yyyy	___/ ___/ _____ mm dd yyyy	___/ ___/ _____ mm dd yyyy

F. HPV (Human Papilloma Virus)

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

HPV Vaccination #1 (oldest):	HPV Vaccination #2:	HPV Vaccination #3 (newest):
___/ ___/ _____ mm dd yyyy	___/ ___/ _____ mm dd yyyy	___/ ___/ _____ mm dd yyyy

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

____