Dear Undergraduate Student:

University Health Services (UHS) would like to welcome you to Boston College. All mandatory health forms are included in this packet. The State of Massachusetts requires that all full-time undergraduate students and part-time undergraduate health science and visa carrying students submit proof of the immunizations listed on the BC Immunization Incoming Form. All forms must be completed, uploaded and entered into the Health Services Portal (see instructions below).

The deadline for submission is July 1st/Fall enrollment (January 1st/Spring enrollment). If all forms have not been uploaded and entered into the Health Services Portal within 30 days before the start of classes you will not be able to register for the following semester classes and an $85 non-refundable late fee will be applied to your student account.

Please note, you do not need to use the BC Immunization Incoming Form or Physical Form in the packet. You can substitute an official record from your provider BUT you are still required to submit all additional forms in this packet. The BC Immunization Incoming Form details which vaccines are required by the State of Massachusetts and those that are highly recommended by UHS. Please make sure that your documentation includes all of the required vaccines listed or positive titers where applicable as well as the completed Health History, Physical and TB Questionnaire and Testing Form. If you have not received all of the required vaccines you will need to obtain them prior to the start of classes.

To submit forms through the Health Services Portal please follow the steps below:

1. Navigate to the BC Agora Portal (https://services.bc.edu) and sign in using your BC username and password
2. Under OTHER SERVICES, click on the HEALTH SERVICES link
3. Once in the Health Services Portal choose the IMMUNIZATION ICON OR TAB and enter the dates of all of your vaccines as indicated on your form. Once you have entered all of the vaccine dates, click the SUBMIT button.
4. Take a picture or scan the individual forms (immunization, health history, physical, tuberculosis questionnaire/testing form and meningitis waiver if applicable and) and save them on your computer or phone to navigate to when uploading the forms to the Portal. Do not use special characters when naming your files.
5. Navigate to the UPLOAD ICON and upload the individual forms to their corresponding line item in the drop down menu (Note: the drop down menu is below the list of “documents available to upload”). Click SELECT FILE, choose the file you are uploading and hit the UPLOAD button with each file. The uploaded documents will appear at the bottom of the page under “Documents Already on File”. Varsity athletes are also required to upload sickle cell lab test results.

Once completed DO NOT send your forms to UHS instead maintain them for your records in case there is a problem with the image quality and you need to resubmit them.

Thank you in advance for your cooperation and best of luck in your studies.

Yours truly,
Douglas Comeau, DO, CAQSM, FAAFP, FAMSSM
Director, University Health Services and Primary Care Sports Medicine
Boston College Health Services

Health History Form

Name ___________________________________________ Preferred Name: __________________________ Date of Birth ___/___/___

(Last Name) (First) (Middle)

Address

(Street) (City/Town) (State) (Zip)

Cell Phone Number: ____________________ E-Mail: __________________________ BC Eagle ID # ____________

In Case of Emergency, notify: __________________________ Relation: __________________________ Cell Phone: ____________

Family Medical History

Relation | Age | General Health | Past/Present Serious Illness | If Deceased/Age | Cause of Death
----------|-----|----------------|-------------------------------|-----------------|-------------------
Parent | | | | |
Parent | | | | |
Sibling | | | | |
Sibling | | | | |
Sibling | | | | |

Use additional page if needed

Student’s Medical History - Check all that apply

Are you adopted? Yes ☐ No ☐

Illness | Yes | No | Comments
---------|-----|----|-------------------
Asthma | | | |
Cancer | | | |
Concussion | | | |
Covid-19 | | | |
Depression | | | |
Diabetes | | | |
Eating Disorder | | | |
Ears/Eyes | | | |

Date of Confirmed Testing: ___/___/___

Yes ☐ No ☐ Reason: __________________________

Are you currently followed by a medical provider for an emotional or psychological disorder? No ☐ Yes ☐ Reason: __________________________

Please notify the Disability Office if you will need accommodations on campus @ 617-552-3470 or student.support@bc.edu

ALLERGIES: Please list ALL Medication AND Food Allergies

Do you carry an Epi-Pen? Yes ☐ No ☐

Name of Medication or Food | Describe Reaction
----------------------------|---------------------

Use additional page if needed

MEDICATIONS: Please list all prescription and non-prescription meds including vitamins & herbal supplements.

Medication Name (print clearly) | Dose | Times per Day
--------------------------------|------|-----------

Use additional page if needed

List any surgical procedures with date: ______________________________________________

Do you smoke or vape? Yes ☐ No ☐

Do you consume alcohol? No ☐ Yes ☐ # drinks per week __________

Do you exercise regularly? Yes ☐ No ☐ Any limits: __________________________

I certify that the information provided is complete and accurate. I have also received notification of the Health Services privacy policy located on UHS website: www.bc.edu/uhs

Student Signature (REQUIRED) __________________________ Date __________________________

***CONSENT FOR TREATMENT OF A MINOR (if < 18 years of age when they arrive on campus)***

I ___________________________ consent to have my child __________________________ receive routine treatment at Boston College Health Services or local hospital should my child become ill/injured while at school.

Parent/Guardian Signature: __________________________ Date: ____________

** Health Insurance Information**

Upload a copy of the front & back of your Insurance card to your health portal. We suggest students keep a copy in their phone. Insurance must be updated annually and when there is a change. Enter information under Medical Insurance in services.bc.edu
Boston College Health Services Physical Form    Eagle ID: __________________________
Completed form must be uploaded by the student to the Health Services Portal (https://osh.bc.edu)

Name: ________________________ Date Of Birth: ___ / ___ / ___

Height: ______  Weight: ______  BMI: ______  BP: ______  Pulse: ______

<table>
<thead>
<tr>
<th>System</th>
<th>Normal</th>
<th>Describe Abnormality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs / Chest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breasts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart / Vascular System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genito-urinary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pelvic (if indicated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphatic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endocrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Recommended Labs for women: Hematocrit – Date: ___ / ___ / ___  Results: __________________

CURRENT AND CHRONIC PROBLEMS:

1. ________________________  2. ________________________
3. ________________________  4. ________________________

ALLERGIES (Please list ALL allergies to medications, foods and other miscellaneous items)

<table>
<thead>
<tr>
<th>MEDICATION ALLERGIES:</th>
<th></th>
</tr>
</thead>
</table>

| FOOD ALLERGIES: |
|-----------------

<table>
<thead>
<tr>
<th>OTHER ALLERGIES:</th>
</tr>
</thead>
</table>

BEES   LATEX   NUTS   SEASONAL / POLLEN

MEDICATIONS (Include prescriptions, over-the-counter, and herbal)

<table>
<thead>
<tr>
<th>NAME</th>
<th>DOSE</th>
<th>FREQUENCY</th>
<th>RELATED DIAGNOSIS</th>
</tr>
</thead>
</table>

****STATEMENT MUST BE CHECKED FOR PARTICIPATION IN SPORTS****

Is this student fit for Varsity or other sports?  YES ___ NO ___

PROVIDER SIGNATURE: _______________________________  DATE OF EXAMINATION: __________

PROVIDER NAME: ___________________________  PHONE: ___________  FAX: ___________
BOSTON COLLEGE IMMUNIZATION INCOMING FORM

Eagle ID# ___________________________________________ Date of Birth_____/_____/_______

Print Last Name ______________________________________ Print First Name __________________________

Status (check all that apply): Undergraduate_____ Graduate _____ Evening _____ Exchange _____ Varsity Athlete _____

REQUIRED IMMUNIZATIONS

If you have chosen to use this immunization form it must be completed and signed by your health care provider.

<table>
<thead>
<tr>
<th>Required Vaccines</th>
<th>Dates Given</th>
<th>MA State Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>#1 / / #2 / / #3 / /</td>
<td>3 doses; laboratory evidence of immunity acceptable; <strong>2 doses of Hepatitis-B</strong> given on or after 18 years of age are acceptable</td>
</tr>
<tr>
<td><strong>Meningococcal Quadrivalent</strong></td>
<td>/ / /</td>
<td>1 dose; The dose of MenACWY vaccine must have been received on or after the student’s 16th birthday or Signed Waiver</td>
</tr>
<tr>
<td><strong>MMR (Measles, Mumps &amp; Rubella)</strong></td>
<td>#1 / / #2 / /</td>
<td>2 doses; first dose must be given on or after the 1st birthday and second dose must be given ≥28 days after first dose; laboratory evidence of immunity acceptable.</td>
</tr>
<tr>
<td><strong>Tdap (Tetanus, Diphtheria, Pertussis)</strong></td>
<td>Tdap / / / *If greater than 10 yrs ago must also provide date of recent Td / / / or Tdap / / / /</td>
<td>If Tdap was given ≥ 10 years ago you must also provide a current Td or Tdap</td>
</tr>
<tr>
<td><strong>Varicella</strong></td>
<td>#1 / / #2 / /</td>
<td>2 doses; first dose must be given on or after the 1st birthday and second dose must be given ≥28 days after first dose; a provider document history of chickenpox or laboratory evidence of immunity is acceptable</td>
</tr>
<tr>
<td><strong>COVID – 19 Vaccine</strong></td>
<td>Vaccine Name: _________________________</td>
<td>Accepted Vaccines: Pfizer-BioNTech Moderna Johnson &amp; Johnson’s Janssen WHO EUL Vaccine</td>
</tr>
<tr>
<td><strong>Influenza</strong></td>
<td>Vaccine for the current flu season should be received annually by December 31st</td>
<td>Once received upload documentation and enter the date in the UHS Portal</td>
</tr>
<tr>
<td><strong>Meningococcal Group B</strong></td>
<td>#1 / / #2 / / #3 / /</td>
<td></td>
</tr>
<tr>
<td>MenB-4C (Bexsero)</td>
<td>#1 / / #2 / / #3 / /</td>
<td></td>
</tr>
<tr>
<td>OR MenB-FHbp (Trumenba)</td>
<td>#1 / / #2 /</td>
<td></td>
</tr>
<tr>
<td><strong>Human Papillomavirus (HPV)</strong></td>
<td>#1 / / #2 / / #3 /</td>
<td></td>
</tr>
<tr>
<td><strong>Hepatitis A</strong></td>
<td>Hep A: 2 doses at least 6 months apart</td>
<td></td>
</tr>
<tr>
<td>OR <strong>Hepatitis A &amp; B Combined</strong></td>
<td>Hep A &amp; B Combined: 3 doses given on a 0, 1, and 6-month schedule</td>
<td></td>
</tr>
</tbody>
</table>

Provider’s Signature: ___________________________ Date: ___________________________
Address (Including City and State): __________________________________________
Phone #: ___________________________ 12/2021
Information about Meningococcal Disease, Meningococcal Vaccines, Vaccination Requirements and the Waiver for Students at Colleges and Residential Schools

Colleges: Massachusetts requires all newly enrolled full-time students 21 years of age and under attending a postsecondary institution (e.g., college) to receive a dose of quadrivalent meningococcal conjugate vaccine on or after their 16th birthday to protect against serotypes A, C, W and Y or fall within one of the exemptions in the law, discussed on the reverse side of this sheet.

Residential Schools: Massachusetts requires all newly enrolled full-time students attending a secondary school who will be living in a dormitory or other congregate housing licensed or approved by the secondary school or institution (e.g., boarding school) to receive quadrivalent meningococcal conjugate vaccine to protect against serotypes A, C, W and Y or fall within one of the exemptions in the law, discussed on the reverse side of this sheet.

The law provides an exemption for students signing a waiver that reviews the dangers of meningococcal disease and indicates that the vaccination has been declined. To qualify for this exemption, you are required to review the information below and sign the waiver at the end of this document. Please note, if a student is under 18 years of age, a parent or legal guardian must be given a copy of this document and must sign the waiver.

What is meningococcal disease?
Meningococcal disease is caused by infection with bacteria called Neisseria meningitidis. These bacteria can infect the tissue that surrounds the brain and spinal cord called the “meninges” and cause meningitis, or they can infect the blood or other body organs. Symptoms of meningococcal disease may appear suddenly. Fever, severe and constant headache, stiff neck or neck pain, nausea and vomiting, sensitivity to light and rash can all be signs of meningococcal disease. Changes in behavior such as confusion, sleepiness, and trouble waking up can also be important symptoms. Less common presentations include pneumonia and arthritis. In the US, about 350-550 people get meningococcal disease each year and 10-15% die despite receiving antibiotic treatment. Of those who live, another 10-20% lose their arms or legs, become hard of hearing or deaf, have problems with their nervous systems, including long term neurologic problems, or suffer seizures or strokes.

How is meningococcal disease spread?
These bacteria are passed from person-to-person through saliva (spit). You must be in close contact with an infected person’s saliva in order for the bacteria to spread. Close contact includes activities such as kissing, sharing water bottles, sharing eating/drinking utensils or sharing cigarettes with someone who is infected; or being within 3-6 feet of someone who is infected and is coughing or sneezing.

Who is at most risk for getting meningococcal disease?
High-risk groups include anyone with a damaged spleen or whose spleen has been removed, those with persistent complement component deficiency (an inherited immune disorder), HIV infection, those traveling to countries where meningococcal disease is very common, microbiologists who work with the organism and people who may have been exposed to meningococcal disease during an outbreak. People who live in certain settings such as first year college students living on campus and military recruits are also at greater risk of disease from some of the serogroups.

Which students are most at risk for meningococcal disease?
In the 1990s, college freshmen living in residence halls were identified as being at increased risk for meningococcal disease. Meningococcal disease and outbreaks in young adults were primarily due to serogroup C. However, following many years of routine vaccination of young people with quadrivalent meningococcal conjugate vaccine (for serogroups A, C, W and Y), serogroup B is now the primary cause of meningococcal disease and outbreaks in young adults. Among the approximately 9 million students aged 18-21 years enrolled in college, there are an average of 20 cases and 0-4 outbreaks due to serogroup B reported annually. Although incidence of serogroup B meningococcal disease in college students is low, four-year college students are at increased risk compared to non-college students; risk is highest among first-year students living on campus. The close contact in college residence halls, combined with social mixing activities (such as going to bars, clubs or parties; participating in Greek life; sharing food or beverages; and other activities involving the exchange of saliva), may put college students at increased risk.

Is there a vaccine against meningococcal disease?
Yes, there are 2 different meningococcal vaccines. Quadrivalent meningococcal conjugate vaccine (Menactra and Menevo) protects against 4 serotypes (A, C, W and Y) of meningococcal disease. Meningococcal serogroup B vaccine (Bexsero and Trumebna) protects against serogroup B meningococcal disease. Quadrivalent meningococcal conjugate vaccine is routinely recommended at age 11-12 years with a booster at age 16. Students receiving their first dose on or after their 16th birthday do not need a booster. Individuals in certain high risk groups may need to receive 1 or more of these vaccines based on their doctor’s recommendations. Adolescents and young adults (16-23 years of age) who are not in high risk groups may be vaccinated with meningococcal B vaccine, preferably at 16-18 years of age, to provide short-term protection for most strains of serogroup B meningococcal disease. Talk with your doctor about which vaccines you should receive.
Is the meningococcal vaccine safe?
Yes. Getting meningococcal vaccine is much safer than getting the disease. Some people who get meningococcal vaccine have mild side effects, such as redness or pain where the shot was given. These symptoms usually last for 1-2 days. A small percentage of people who receive the vaccine develop a fever. The vaccine can be given to pregnant women. A vaccine, like any medicine, is capable of causing serious problems such as severe allergic reactions, but these are rare.

Is meningococcal vaccine mandatory for entry into secondary schools that provide housing, and colleges?
Massachusetts law (MGL Ch. 76, s.15D) and regulations (105 CMR 220.000) requires both newly enrolled full-time students attending a secondary school (those schools with grades 9-12) who will be living in a dormitory or other congregate housing licensed or approved by the secondary school or institution and newly enrolled full-time students 21 years of age and younger attending a postsecondary institution (e.g., colleges) to receive a dose of quadrivalent meningococcal conjugate vaccine.

At affected secondary schools, the requirements apply to all new full-time residential students, regardless of grade (including grades pre-K through 8) and year of study. Secondary school students must provide documentation of having received a dose of quadrivalent meningococcal conjugate vaccine at any time in the past, unless they qualify for one of the exemptions allowed by the law. College students 21 years of age and younger must provide documentation of having received a dose of quadrivalent meningococcal conjugate vaccine on or after their 16th birthday, regardless of housing status, unless they qualify for one of the exemptions allowed by the law. Meningococcal B vaccines are not required and do not fulfill the requirement for receipt of meningococcal vaccine. Whenever possible, immunizations should be obtained prior to enrollment or registration. However, students may be enrolled or registered provided that the required immunizations are obtained within 30 days of registration.

Exemptions: Students may begin classes without a certificate of immunization against meningococcal disease if: 1) the student has a letter from a physician stating that there is a medical reason why he/she can’t receive the vaccine; 2) the student (or the student’s parent or legal guardian, if the student is a minor) presents a statement in writing that such vaccination is against his/her sincere religious belief; or 3) the student (or the student’s parent or legal guardian, if the student is a minor) signs the waiver below stating that the student has received information about the dangers of meningococcal disease, reviewed the information provided and elected to decline the vaccine.

Shouldn’t meningococcal B vaccine be required?
CDC’s Advisory Committee on Immunization Practices has reviewed the available data regarding serogroup B meningococcal disease and the vaccines. At the current time, there is no routine recommendation and no statewide requirement for meningococcal B vaccination before going to college (although some colleges might decide to have such a requirement). As noted previously, adolescents and young adults (16 through 23 years of age) may be vaccinated with a serogroup B meningococcal vaccine, preferably at 16 through 18 years of age, to provide short term protection against most strains of serogroup B meningococcal disease. This would be a decision between a patient or parent and a healthcare provider. These policies may change as new information becomes available.

Where can a student get vaccinated?
Students and their parents should contact their healthcare provider and make an appointment to discuss meningococcal disease, the benefits and risks of vaccination, and the availability of these vaccines. Schools and college health services are not required to provide you with this vaccine.

Where can I get more information?
• Your healthcare provider
• The Massachusetts Department of Public Health, Division of Epidemiology and Immunization at (617) 983-6800 or www.mass.gov/dph/imm and www.mass.gov/dph/epi
• Your local health department (listed in the phone book under government)

Waiver for Meningococcal Vaccination Requirement
I have received and reviewed the information provided on the risks of meningococcal disease and the risks and benefits of quadrivalent meningococcal conjugate vaccine. I understand that Massachusetts’ law requires newly enrolled full-time students at secondary schools who are living in a dormitory or congregate living arrangement licensed or approved by the secondary school, and newly enrolled full-time students at colleges and universities who are 21 years of age or younger 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.

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

Student Name: __________________________ __ Date of Birth: ________ Student ID: __________

Signature: ______________________________ Date: ____________________

(Student or parent/legal guardian, if student is under 18 years of age)
Please refer to this list of countries/territories below when responding to questions #4 and #5

Afghanistan, China, Macao SAR
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Côte d'Ivoire
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
Colombia
Comoros
Congo
Democratic People's Republic of Korea
Democratic Republic of the Congo
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Haiti
Honduras
India
IndoOnesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Thailand
Togo
Tokelau
Trinidad and Tobago
Tunisia
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe


1. Did you ever receive a BCG vaccine as a child?  
2. Have you ever had close contact with persons known or suspected to have active TB disease?  
3. Have you ever had a history of a positive PPD skin test?  
4. Were you born in one of the countries or territories listed above that have a high incidence of active TB disease? (If yes, please CIRCLE the country)  
5. Are you a recent arrival (<5 years) from one of the high prevalence areas listed above? 
   If YES please indicate date of arrival: / /  
6. Have you had frequent or prolonged visits (for more than one month) to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CHECK the country/countries)  
7. Have you been a health care worker, volunteer, resident and/or employee of high-risk congregate settings or served clients who are at increased risk of active TB disease (e.g., correctional facilities, long-term care facilities, homeless shelter, substance abuse treatment, rehabilitation facility)?  
8. Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease – medically underserved, low income or abusing drugs or alcohol?  

If the answer is YES to any of the above questions, Boston College requires that you receive TB testing as soon as possible but at least prior to the start of the semester. Have your physician complete and return the Tuberculosis (TB) Risk Assessment on pages 2 and 3 with additional testing and/or documentation as needed.

If the answer to all of the above questions is NO, no further testing is required (no need to complete page 2 & 3).
Date: __________________ Name: ___________________________ 
Eagle ID#: __________________ Last Name: ____________________ Date of Birth: ____________________ First Name: __________________________ 
Cell Phone: ___________________________ Email: _____________________________

**TUBERCULOSIS (TB) RISK ASSESSMENT (to be completed by health care provider)**

Clinicians should review and verify information on the TB Screening Form. Persons answering YES to any of the questions are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test is documented.

History of a positive TB skin test or IGRA blood test? Yes _____ No _____ (If Yes, and received previous treatment complete the TB Symptom Check and the Medication Section)

History of BCG vaccination? (If yes, consider IGRA if possible.) Yes _____ No _____

1. **TB Symptom Check**

Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes _____ No _____

If No, proceed to 2 or 3

If yes, check below:
- Cough (especially if lasting for 2-3 weeks or longer) with or without sputum production
- Coughing up blood (hemoptysis)
- Chest pain
- Loss of appetite
- Unexplained weight loss, unusual weakness or extreme fatigue
- Night sweats
- Fever

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. **Tuberculin Skin Test (TST)**

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write “0”. The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: __________ / ______ / ______ Date Read: __________ / ______ / ______

**Result: ________ mm of induration ** Interpretation (please refer to interpretation guidelines): positive _____ negative _____

(If positive Chest X-Ray required see pg 3 of 3)

**Interpretation guidelines**

>5 mm is positive:
- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- Organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for 1 month or more)
- HIV-infected persons

>10 mm is positive:
- Recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- Injection drug users
- Mycobacteriology laboratory personnel
- Residents, employees, or volunteers in high-risk congregate settings for example prisons, long term care facilities, health care facilities, homeless shelters, residential facilities for patients with HIV/AIDS
- Persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer/hematologic disorders (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.
- Children < than 4 years of age or infants, children and adolescents exposed to adults at high-risk

>15 mm is positive:
- Persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

*The significance of the travel exposure should be discussed with a health care provider and evaluated.

Health Care Provider’s Signature: ___________________________________________________________ (Continue on page 3)
BOSTON COLLEGE UNIVERSITY HEALTH SERVICES
TUBERCULOSIS (TB) QUESTIONNAIRE AND TESTING FORM

Date: __________________________ Name: __________________________
Eagle ID#: __________________________ Date of Birth: __________________________
Cell Phone: __________________________ Email: __________________________

3. Interferon Gamma Release Assay (IGRA)
   Date Obtained: ______/_____/______ (specify method) QFT-GIT T-Spot other _____
   Result: negative____ positive____ indeterminate____ borderline____ (T-Spot only)

4. Chest x-ray: (Required if TST or IGRA is POSITIVE)
   Date of chest x-ray: ______/_____/______ Result: normal____ abnormal____

TUBERCULOSIS (TB) RISK ASSESSMENT Management of Positive TST or IGRA
All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- Infected with HIV
- Recently infected with M. tuberculosis (within the past 2 years)
- History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- Have had a gastrectomy or jejunoileal bypass
- Weigh less than 90% of their ideal body weight
- Cigarette smokers and persons who abuse drugs and/or alcohol

••Populations defined locally as having an increased incidence of disease due to M. tuberculosis, including medically underserved, low income populations

MEDICATION SECTION:
Was the patient educated and counseled on latent tuberculosis and advised to take medication because of the positive results? NO_______ YES ________

_______ Patient agrees to receive treatment
If yes, what medication(s) was prescribed? ______________ Date Started: ______/_____/______ Date Ended: ______/_____/______

_______ Patient declines treatment at this time

HEALTH CARE PROVIDER
Name____________________________ Signature __________________________
Address __________________________
Phone (__________) __________________________

Page 3 of 3
Rev 6/2020
**Please Note: It is your responsibility to provide accurate and thorough information regarding your insurance. Failure to do so may result in a bill from the Lab being sent to the Policy Holder.

***Please Note: There may still be a co-pay/deductible requirement that must be paid depending on individual insurance plans or charges for out of network services, which will be your responsibility to pay.

University Health Services is not responsible for any charges incurred for lab work.

By completing this form you acknowledge the above information.

PLEASE BE SURE TO COPY ALL INSURANCE ACCURATELY FROM YOUR INSURANCE CARD TO AVOID UNNECESSARY BILLING ISSUES.

Your Name: ___________________________________________ Eagle ID #: __________________________________

LAST NAME                                 FIRST NAME

Your Home Address:

Street Address: ___________________________________________________________________________________

City/Town ___________________________ State: ____________ Zip Code: _________________

Your Cell Phone Number: (______) _______-_________

E-mail (International Students): ______________________________________________________________

Name of Policy Holder: ______________________________________________________________

Relationship to you (student): Please Check

   Self: _____ Parent/Guardian _______ Spouse _________ Other (explain) __________

Address of Policy Holder:

Street Address: ___________________________________________________________________________________

City/Town ___________________________ State: ____________ Zip Code: _________________

Name of Insurance Company: ________________________________

Insurance Policy #: ________________________________

Group # (if one is listed on the insurance card) ________________________________

Insurance Company Address: (usually found on the back of the card)

____________________________________________________________________________________

____________________________________________________________________________________

Insurance Company Phone (if available on card): (______) ______ - _______
Boston College
University Health Services
Informed Consent for Telehealth

This section contains important information focusing on telehealth using the phone or the Internet. Please read this carefully, and let UHS staff know if you have any questions.

Benefits and Risks of Telehealth

Telehealth refers to providing medical consultation remotely using telecommunications technologies, such as video conferencing or telephone. One of the real benefits of telehealth is that the patient and provider can engage in services without being in the same physical location.

Telehealth also may ensure continuity of care during public health emergencies in which physical distancing is advised, therefore protecting the health of the patient. Telehealth, however, requires technical competence on both our parts to be helpful.

Although there are benefits of telehealth, there are some differences between in-person evaluation and telehealth, as well as some risks. For example:

• **Risks to Confidentiality**: Because telehealth sessions take place outside of the provider’s private office, there is potential for other people to overhear sessions if you are not in a private place during the session. UHS staff will take reasonable steps to ensure your privacy. It is equally important that you make sure to find a private place for sessions where you will not be interrupted. It is also important for you to protect the privacy of sessions on your cell phone or other device. You should participate in telehealth only while in a room or area where other people are not present and cannot overhear the conversation.

• **Issues Related to Technology**: There are many ways that technology issues might impact telehealth. For example, technology may stop working during a telehealth visit, other people might be able to get access to private conversations, or stored data could be accessed by unauthorized people or companies.

Confidentiality

UHS has a legal and ethical responsibility to make best efforts to protect all communications that are a part of telehealth. However, the nature of electronic communications technologies is such that UHS cannot guarantee that our communications will be kept confidential or that other people may not gain access to communications. UHS will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that electronic communications may be compromised, unsecured, or accessed by others. You should
also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telehealth sessions and having passwords to protect the device you use for telehealth).

**Emergencies and Technology**

If the session is interrupted for any reason, such as the technological connection fails, and you are having a life-threatening emergency and cannot wait for a call back, do not call your provider back; instead, call 911, or Boston College Police Department at 617-552-4444, or go to your nearest emergency room. Call your provider back after you have obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and wait a few minutes while your provider re-contacts you via the telehealth platform. If you do not receive a call back within a few minutes, then call our office number (617-552-3225).

**Records**

The telehealth sessions shall not be recorded in any way unless agreed to in writing by mutual consent. UHS will maintain a record of visits in the same way it maintains records of in-person sessions in accordance with its policies.

**AGREEMENT**

By completing the information below you are acknowledging that you have read the *Information about Informed Consent for Telehealth*, and that you agree to the conditions they describe.

Please complete this FILLABLE form, save it to your desktop/mobile device and upload it to the Health Services Portal (Agora – Other Services) under *Telehealth Consent* in the dropdown menu.

Eagle ID # __________________________________________
Birthdate __________________________________________
Name __________________________________________
Preferred name __________________________________
Pronouns (e.g., she, her, they, them, ze, zem, zirs, hirs)

Written 8/22/20