BOSTON COLLEGE

UNIVERSITY HEALTH SERVICES

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 $80 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. 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. Take a picture or scan the **individual** forms (immunization, meningitis waiver if applicable and tuberculosis questionnaire/testing form) and save them on your computer or phone to navigate to once logged into the Health Services Portal. *Do not use special characters when naming your files.*
2. Navigate to the **BC Agora Portal (https://services.bc.edu)** and sign in using your BC username and password
3. Under **OTHER SERVICES** click on the **HEALTH SERVICES** link
4. Once in the Health Services Portal choose 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.**
5. *Most Important Final Step: Once forms have been uploaded go to the top of the page and select the **IMMUNIZATION LINK** 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.

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,
Thomas I. Nary, M.D. Director
University Health Services

Varsity Student Athlete: Yes__ No __

BOSTON COLLEGE HEALTH SERVICES
HEALTH HISTORY

Expected Graduation Year _____

Name_____ Date of Birth ___/___/_ __ B.C. Eagle #_____
(Last Name) (First) (Middle I)

Address_____
(Street) (City) (State) (Zip Code)

Tel# _____Cell Phone #_____Email_____

In case of emergency, notify_____Relation_____Cell #_____

*****Health Insurance plan: Attach copy of front & back of student's insurance card for our files *****

Insurance Company Name _____Policy #_____
Group #_____ Policy Holder_____ Relationship_____
Contact # for out of plan service_____ Is this an HMO? Yes/ No
If Insurance plan changes, please notify Health Services and update insurance information @ bc.edu/agora

*****CONSENT FOR TREATMENT OF MINOR (if under the age of 18 when first entering BC)*****

I consent to have my son/daughter receive routine treatment at the Boston College health Services or local hospital should he/she become ill or injured while at school.

Parent/ Guardian's signature_____ Date_____

FAMILY MEDICAL HISTORY

Relation	Age	General Health	Past/Present Serious Illness	If Deceased/ Age	Cause of death
Father					
Mother					
Brother/Sister					
Brother/Sister					

STUDENT'S MEDICAL HISTORY

Are you adopted? Yes___ No____

Illness	Age	Illness	Age	Illness	Age	Illness	Age	Illness	Age
Acne		Chickenpox		Epilepsy		Kidney/Urinary		Paralysis	
ADD/ADHD		Concussion		German Measles		Infectious Mono		Rheumatic Fever	
Asthma		Depression		Heart		Measles		Thyroid	
Cancer		Diabetes		Hepatitis		Mumps		Tuberculosis	

Are you allergic to medications? Yes / No If yes, please list:	Any food /environmental allergies? Yes / No If yes, please list:	Are you being followed by a physician for any medical condition /problem? Yes / No If yes, please list:
What medications do you regularly take? Please list:	Will you need specific medical assistance, e.g. allergy injections, physical disability accommodations? Yes / No Explain	Please list types and dates of any hospitalizations, surgical operations.
Any psychological/emotional issues, or eating disorders? Yes / No. Explain	Any vision or hearing problems? Yes / No Explain: Do you smoke? Yes / No How often do you exercise? Any limits?	Have you ever been ill or injured from alcohol use? Yes / No Explain: Have you ever been unconscious? Yes / No Explain.

Revised 6/2014

THIS MUST BE SIGNED BY THE STUDENT: I certify that the information entered above is complete and accurate. I have also received notification of the Health Services privacy policy, which is located on their website www.bc.edu/health_services

Student Signature_____ Date:_____

BOSTON COLLEGE HEALTH SERVCIES
PRE-ENTRANCE PHYSICAL

Name_____ Date of Birth___/___/___ BC Eagle #_____
Last First Middle Initial

****SUBMIT REQUIRED MEDICAL INFORMATION ON THESE FORMS ONLY****

TO THE EXAMINING PHYSICIAN:
Once this student has been accepted to the school, we would appreciate learning about any problems or accomodations which would require special attention.

PHYSICAL EXAMINIATION: In answering these questions, please use the term Negative or Normal.

General Development:			**Weight**		**Height**
Blood Pressure:			**Pulse**		**Skin**
Vision	**Rt. /**	**Left /**	**Glasses:**	**Rt. /**	**Left /**
Head:	**Eyes**	**Ears (hearing)**	**Nose**	**Throat**	**Teeth**
Neck:	**Thyroid**	**Nodes**		**Range of Motion**	
Chest:	**Lungs**	**Axillary Nodes**		**Breasts**	
	Heart				
Abdomen:		**Hernia**	**Inguinal Nodes**		**Testes**
Skeletal:	**Arms**	**Legs**		**Back**	
Vascular:	**Pulses (femoral,pedal)**		**Varicosities**		
Neurological:	**Gait**	**Patellar Tendon Reflexes**	**Achilles Tendon Reflexes**		**Balance**
Hematocrit: (women)	**Date ___/___/___**	**Results**			
Summary:					

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

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

Physician's Name_____

Office Address_____ Telephone_____

Signature_____ Date_____

Revised 4/2018

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 _____

Anticipated year of Graduation _____

REQUIRED IMMUNIZATIONS

If you have chosen to use this immunization form it must be completed and signed by your health care provider. BE AWARE: MA state law requires immunization compliance. If 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 $80 non-refundable late fee will be applied to your student account.

Required Vaccines	Dates Given	MA State Requirements
Hepatitis B	#1___/___/___ #2___/___/___ #3___/___/___ **OR** Positive Titer HBs AB Date:___/___/___	3 doses **OR** Positive Titer Usual schedule at 0,1 & 4 months Minimum 4 weeks between doses 1 and 2 Minimum 8 weeks between doses 2 and 3 Minimum 16 weeks between 1 and 3
Meningococcal Quadrivalent (ALL Full Time Students 21 years or younger)	___/___/___ **Please check which vaccine administered:** Menactra ___ or Menveo ___ Nimenrix ___**OR** signed waiver____	MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135) (Menactra, Menveo or Nimenrix) for **all** full time students 21 years of age and younger on or after the 16th birthday **or Signed Waiver (See Information about Meningococcal Disease and Waiver Form)**
MMR (Measles, Mumps & Rubella Combined) **OR** **Alternate: Individual vaccines or titers** **Measles** **Mumps** **Rubella**	#1___/___/___ #2___/___/___ #1___/___/___ #2___/___/___ OR Positive Titer Date: ___/___/___ #1___/___/___ #2___/___/___ OR Positive Titer Date: ___/___/___ #1___/___/___ #2___/___/___ OR Positive Titer Date: ___/___/___	**1st dose given after 1st birthday** 2 doses - Minimum of 4 weeks between doses **OR** Individual vaccines **OR** Positive Titers
Tdap (Tetanus, Diphtheria, Pertussis)	Tdap ___/___/___ *If **greater than 10 yrs from date of enrollment** must provide date of recent Td ___/___/___	Tdap one dose (after June 2005) *If Tdap date **is greater than 10 yrs from date of enrollment** you must provide date of recent Td (tetanus,diphtheria) or Tdap booster
Varicella	#1___/___/___ #2___/___/___ **OR** Positive Titer Date ___/___/___ **OR** History of disease: Yes ___ No ___ Date:___/____/____	**1st dose given after 1st birthday** 2 doses - Minimum of 4 weeks between doses **OR** Positive Titer **OR** history of disease
	ADDITIONAL IMMUNIZATIONS	**STANDARD DOSING**
Meningococcal Group B **MenB-4C (Bexsero)** **OR** **MenB-FHbp (Trumenba)** ***THIS VACCINE IS STRONGLY RECOMMENDED***	#1___/___/___ #2___/___/___ #1___/___/___ #2___/___/___ #3___/___/___	2 doses at least one month apart 3 doses at 0, 2 and 6 months
Human Papillomavirus (HPV) ***THIS VACCINE IS STRONGLY RECOMMENDED***	#1___/___/___ #2___/___/___ #3___/___/___	3 doses at 0, 2 & 6 months
Hepatitis A **OR** **Hepatitis A & B Combined**	#1___/___/___ #2___/___/___ #1___/___/___ #2___/___/___ #3___/___/___	Hep A: 2 doses at least 6 months apart **Hep A & B Combined:** 3 doses given on a 0, 1, and 6-month schedule

Provider's Signature: _____ **Date:** _____

Address (Including City and State): _____

Phone #: _____

6/2019

Updated January 2018

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., colleges) 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 schools) to receive a dose of 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 meningitis may appear suddenly. Fever, severe and constant headache, stiff neck or neck pain, nausea and vomiting, and rash can all be signs of meningitis. Changes in behavior such as confusion, sleepiness, and trouble waking up can also be important symptoms. In the US, about 1,000-1,200 people get meningococcal disease each year and 10-15% die despite receiving antibiotic treatment. Of those who live, another 11-19% 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 college freshmen living in dormitories and military recruits are also at greater risk of disease from some of the serogroups.

Are some students in college and secondary schools at risk for meningococcal disease?
College freshmen living in residence halls or dormitories are at an increased risk for meningococcal disease caused by some of the serotypes contained in the quadrivalent vaccine, as compared to individuals of the same age not attending college. The setting, combined with risk behaviors (such as alcohol consumption, exposure to cigarette smoke, sharing food or beverages, and activities involving the exchange of saliva), may be what puts college students at a greater risk for infection. There is insufficient information about whether new students in other congregate living situations (e.g., residential schools) may also be at increased risk for meningococcal disease. But, the similarity in their environments and some behaviors may increase their risk.

The risk of meningococcal disease for other college students, in particular older students and students who do not live in congregate housing, is not increased. However, quadrivalent meningococcal vaccine is a safe and effective way to reduce their risk of contracting this disease. In general, the risk of invasive meningococcal B disease is not increased among college students relative to others of the same age not attending college. However, outbreaks of meningococcal B disease do occur, though rarely, at colleges and universities. Vaccination of students with meningococcal B vaccine may be recommended during outbreaks.

(see reverse side)

Is there a vaccine against meningococcal disease?
Yes, there are 2 different meningococcal vaccines. Quadrivalent meningococcal conjugate vaccine (Menactra and Menveo) protects against 4 serotypes (A, C, W and Y) of meningococcal disease. Meningococcal serogroup B vaccine (Bexsero and Trumenba) protects against serogroup B meningococcal disease. 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 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, 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.

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 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)

BOSTON COLLEGE UNIVERSITY HEALTH SERVICES
TUBERCULOSIS (TB) QUESTIONNAIRE
AND TESTING FORM

Date: _____ Name: _____
Last First

Eagle ID#: _____ Date of Birth: _____

Cell Phone: _____ Email: _____

Please refer to this list of countries below when responding to questions #4 and #5

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries and territories with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

1. Did you ever receive a BCG vaccine as a child?	❑ Yes	❑ No	❑Unsure
2. Have you ever had close contact with persons known or suspected to have active TB disease?	❑ Yes	❑ No	
3. Have you ever had a history of a positive PPD skin test?	❑ Yes	❑ No	
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)	❑ Yes	❑ No	
5. Are you a recent arrival (<5 years) from one of the high prevalence areas listed above? If **YES** please indicate date of arrival: ____/____/____	❑ Yes	❑ No	
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)	❑ Yes	❑ No	
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)?	❑ Yes	❑ No	
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?	❑ Yes	❑ No	

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 pages 2 & 3).

BOSTON COLLEGE UNIVERSITY HEALTH SERVICES
TUBERCULOSIS (TB) QUESTIONNAIRE AND TESTING FORM

Date: _____ Name: _____
Last First

Eagle ID#: _____ Date of Birth: _____

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? **No** _____ **Yes** _____ **(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: ___/___/___ (M D Y) Date Read: ___/___/___ (M D Y)

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) SCREENING/TESTING FORM

Date: _____ Name: _____
Last First

Eagle ID#: _____ Date of Birth: _____

Cell Phone: _____ Email: _____

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ___/___/____ (specify method) QFT-GIT T-Spot other ____
M D Y

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___
M D Y

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 ( ) _____ **Please Return Form(s) to:**