

RHODE ISLAND COLLEGE
Health Services
600 Mt. Pleasant Ave.
Providence, RI 02908
Phone: (401) 456-8055 Fax: (401) 456-8890

IMMUNIZATION RECORD

This side must be completed and signed by a health care provider.

REQUIRED FOR FULL-TIME GRADUATE AND UNDERGRADUATE STUDENTS, AND ALL INTERNATIONAL STUDENTS

You will be unable to register for classes if you have not provided proof of required immunizations.

Student Name: _____ **Date of Birth:** _____
Last name First MI

Social Security #: _____ - _____ - _____ **College I.D. #:** _____

1. Tetanus-Diphtheria (Td) Booster: One dose within previous 10 years Date: ____ / ____ / ____
or Tetanus-Diphtheria-Pertussis (Tdap) Date: ____ / ____ / ____ (required for nursing majors if ≥ 2 yrs. since last Td)

2. Measles, Mumps, and Rubella Vaccine (MMR): Two doses given a minimum of four weeks apart. First dose must be given on or after first birthday. Students born on or before 12/31/56 are exempt from the second dose.

Dose # 1: ____ / ____ / ____ Dose # 2: ____ / ____ / ____
or

Measles: Two doses (Doses given prior to 1968 are not valid unless it is documented that a live virus vaccine was used.)
Dose # 1: ____ / ____ / ____ Dose # 2: ____ / ____ / ____ **or** a positive IgG titer: ____ / ____ / ____

Mumps: One dose (2 doses required for Nursing majors): Dose # 1: ____ / ____ / ____ **or** a positive IgG titer: ____ / ____ / ____
Dose # 2: ____ / ____ / ____

Rubella: One dose; must be given on or after first birthday: ____ / ____ / ____ **or** a positive IgG titer: ____ / ____ / ____

3. Hepatitis B: Three doses; second dose must be given a minimum of four weeks after first dose. Third dose must be given a minimum of sixteen weeks after first dose and a minimum of eight weeks after second.

Dose # 1: ____ / ____ / ____ Dose # 2: ____ / ____ / ____ Dose # 3: ____ / ____ / ____
or a positive Hepatitis B titer* (anti-HBs [or HBs-AB] >10mIU/mL): ____ / ____ / ____
***nursing majors: titer recommended 1-2 months following dose #3**

4. Varicella (Chickenpox): History of disease confirmed by a provider (**age or year required**): _____
or Varicella Vaccine: Two doses at least four (4) weeks apart:

Dose # 1: ____ / ____ / ____ Dose # 2: ____ / ____ / ____
or a positive Varicella IgG titer: ____ / ____ / ____

The following is strongly recommended, especially for freshman living in residence halls.

5. Meningococcal Vaccine (Menaetra or Menomune) Date: ____ / ____ / ____
[Circle One]

Health Care Provider (Please print): _____ **Date:** _____
Signature and Title: _____ **Office phone:** _____